ROCKY MOUNTAIN MEDICAL JOURNAL

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Publication Office
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Denver 2, Colorado
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November 1959, Volume 56, Number 11

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. . . . The pages that are missing were removed because they were advertisements.

AS YOU LIKE IT...

A medical potpourri

Compiled by Andrew M. Babey, M.D., Las Cruces, New Mexico

1. "X-ray is the only available method of diagnosis of loss of bone mass or osteoporosis. Unfortunately, it is not sufficiently sensitive to detect osteoporosis before one-third of the total volume of the skeleton is lost. . . . For the present, it is reasonable to suppose that diet and sex, thus, are contributory factors and that some other unknown endocrine factor exists and must be found before we know the specific cause and the effective cure for osteoporosis." Urist, M. R.: The Etiology of Osteoporosis, J.A.M.A. **169**:131/710-132/711 (Feb. 14) 1959.

2. "We all remember Azassiz's famous reply to a proposition to deliver one lecture for a large fee: 'I must decline, gentlemen; I have no time to make money'." Vanderbilt, Arthur T. (Editor): Studying Law, New York, Washington Square Publishing Corporation, 1945.

3. "In the matter of food, I subscribe to A. J. Leibling's immortal dictum that an Englishman instructing an American is 'a case of the blind leading the one-eyed'." Cooke, Alistair: Manchester Guardian Weekly, March 19, 1959.

4. "Clinical judgment implies force of character, real innate wisdom, human interest and experience. . . . The clinical sense is a quality that we recognize easily in our fellows and our teachers, yet it is surprisingly difficult to define; the good clinician may know no more than we do; he may be inferior to us in degrees, academic qualifications, and medical school prizes. He sees the same cases that we do, elicits the same history, and makes the same physical examination. But to his inquiry he brings something more." Ogilvie, Sir William H.: Surgery: orthodox and heterodox, ed. 4, Baltimore, Williams & Wilkins, 1949, pages 75 & 76.

5. "Originality and research are often coupled, as if they were synonymous; they are not the same, rather are they in many ways opposite and incompatible. Originality, vision, imagination, are of the soul, research is of the mind. Originality runs ahead with her eyes in the clouds; she may trip up or she may find paradise. Research plods with her eyes on the road; to her the journey is more than its end. Originality is inspiration, research is constant inquiry." Ibid. page 29.

6. "The teacher should never, figuratively at any rate, mount the platform. The six feet that separate the rostrum from the front bench are seldom spanned, but the barrier between experience and immaturity melts before personal contact." Ibid. page 32.

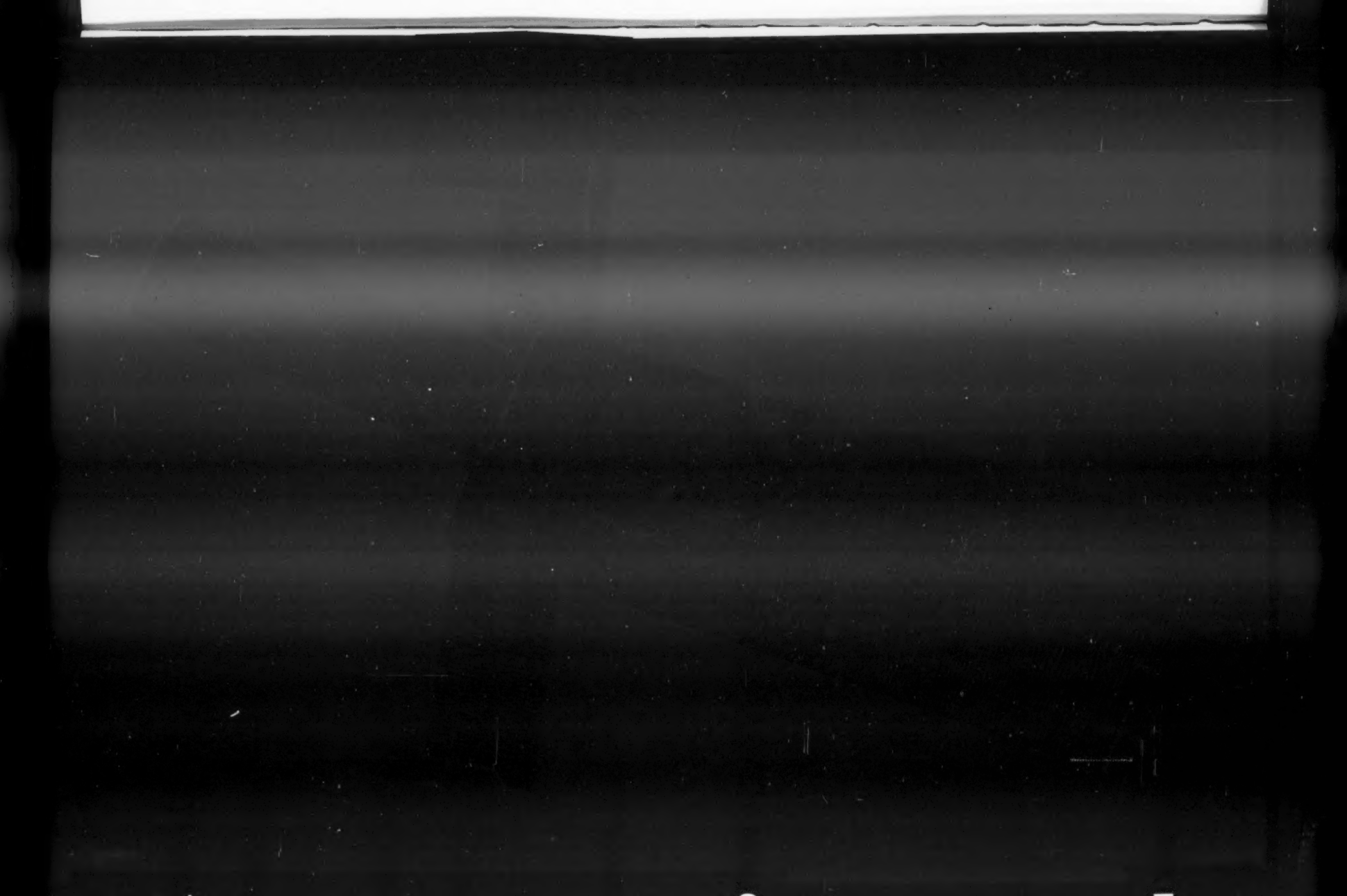
7. "The worst thing that can happen to a young surgeon is that he should go immediately after taking his fellowship to a post where he has abundant practical work, but no time to read or attend meetings, no time to think and write, and —still worse—no one to criticise or ask questions." Ibid. page 34.

8. "The removal of a chronic appendix can do nothing but good, and the removal of a normal appendix in all honesty can do no harm. On the other hand, there is no operation more disastrous than facile appendicectomy where the disease is in the patient's mind or the surgeon's morals." Ibid. page 38.

9. "Unity and friendship among the doctors of a district is most easily brought about by the pleasant and free intercourse which a well-conducted dinner meeting of a medical society provides." Ibid. page 233.

10. "Specialization arises in several ways. It may be called into being by the demands of the public, by the needs of work, or by personal inclination. The public is always seeking what it believes to be the best, and having no standards of its own it will be guided by a label. Knowing nothing of degrees, appointments, published work, or established reputation, it flocks to the 'Harley Street specialist,' not realizing that a brass plate sometimes represents nothing but brass, and that the Harley Street district, besides being the home of the elect, harbours many rogues." Ibid. page 39.

11. "In judging a surgeon we must consider qualities of the head, the heart, and the hand." Ibid. page 42.



I AM GRATEFUL for the invitation from the Wyoming Editor to express my views on matters of great concern to American Medicine, as seen from my new vantage point as director of A.M.A.'s socio-economic activities.

New Perspective

My previous experience has been in the field of private practice and public health administration. It is my general conclusion that, while most physicians realize the hazards of further government intrusion into the field of medical care, they are not fully aware of the implications in Forand type legislation now "hanging fire" in Congress.

Let us begin with the positive side of the matter. One can say that the A.M.A. is now reasonably well satisfied with the manner in which officials of the Bureau of Old Age and Survivors Insurance (BOASI) are selecting disabled individuals above the age of 50 in need of the coverage provided by the present law. These recipients are paid dollars with which they can, by free choice, purchase the necessities of life (including medical care).

Those collectivists who would promote government controlled medical care, see in Forand type legislation a way to begin their program by appealing emotionally for a service type medical care program under federal government control. They do not consider that these are not necessarily the people in greatest need, or that this is a change in philosophy as to how care should be rendered.

The average physician should know that within A.M.A. headquarters there is a special task force. This group, while concerned with the immediate problem of Forand type legislation, is also focusing equally on Medicine's positive program for covering the entire population spectrum. We must remember that not only are there more aged persons, but there are also more young people. In order to further what we believe to be American Medicine's and the nation's best interests, the private practicing physician must exemplify the advantage of that precious heritage "private medical practice." The patient goes to a physician of his or her own choice; a physician completes the arrangement by accepting the patient. Only in this way can the initimate physician-patient relationship be obtained. This is the basis for the present high quality of care in America. A task force in A.M.A. can help Medicine when this relationship between physician and patient is right, but endless numbers of task forces could not help if the relationship is wrong.

In summary, A.M.A. is alert to a very present danger in Forand type legislation. Individual physicians also need to be just as alert and, in addition, continue to carry out a positive program for high level medical care in this atomic, electronic, space, autologic* and, most important to us, modern medical age.

Franklin D. Yoder

FACING, AS WE DO, CRITICISM by editorial writers, articles designed to be more sensational than factual, and attacks by pseudo-scientists and trouble mongers, this Journal has frequently risen to our defense. It remains our firm belief that the vast majority of physicians are honest, but the occasional "rotten apple" does more harm to public relations than hundreds of us can neutralize by years of faithful practice. We have stated that practicing according to the Golden Rule will answer all our critics and will forever postpone governmental direction and control of our profession.

The Surgical Conscience

Another tenet has come from the pen of Dr. W. A. Altemeier in the Archives of Surgery:

Conscience in surgery means a strong sense of right and wrong, a willingness to help others, a

*"Machines that help man think."

feeling of compassion for the unfortunate, self-discipline, and a strong faith in the sanctity of God and man. It can be conditioned by education and experience. It depends not only on the surgeon's individual moral fiber and religious concepts, but also on his heritage of philosophic doctrines, his scientific and factual knowledge, and his judgment. It determines his conduct in many situations, such as the current difficulty with hospital-acquired infections, where temporary individual gains from the misuse of antibiotics may result in protracted trouble to a community. It compels the surgeon at times to resist popular demands and to have the moral courage to protest. It requires him to rise above the selfishness of small professional groups and to devote himself to the individual patient with gentleness, compassion, firmness, and resolution. Many of the current problems concerning the care of the sick are complicated, not solved, by rigid regulations and dictatorial authority. Their solution depends, rather, on a rebirth of the surgical conscience.

This splendid message bespeaks the stature of its author. It may be secondary to the Golden Rule, but is it not therein implied? In this era of impersonalization of services, let us cling rigidly to our respect for the feeling and comfort of patients — the sole reason for our existence as an honored profession!

WGO Lists Meetings of Note

THIS MONTH RMMJ BEGAN PUBLICATION of a new "monthly" to go to doctors in the following states: Alaska, Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Wyoming, and Washington. The medical societies in these states are cooperating in the project.

Called "What goes on," the publication will include in its listings news of postgraduate sessions and meetings of specialized medical organizations and area medical societies.

"WGO" is underwritten by Lederle Laboratories, Division of the American Cyanimid Company, and is sent free of charge to all physicians in the 11-state region. "What goes on" will also serve as a clearinghouse for advance dates of medical meetings in the area.

The Federal Employees Benefit Program

AS THE RESULT OF RECENT CONGRESSIONAL action, our federal employees, nearly two million in number, will soon purchase a prepaid hospital and medical care contract. This bloc of employees will constitute the largest single group ever to be covered by either commercial insurance or Blue Cross-Blue Shield. There are two major effects of this action that are of interest to the medical profession: (1) the effect on Blue Cross-Blue Shield, and (2) the effect on medical fees.

The effect on Blue Cross-Blue Shield will be good if these non-profit, hospital and doctor controlled organizations are successful in obtaining these subscribers. The reason is rather simple—government employees are, for the most part, stable, average income, intelligent, relatively healthy Americans. Subscribers such as these are needed to balance off the low income, high risk citizens that only Blue Cross-Blue Shield make any effort to cover. If commercial insurance companies are able to "skim off" the better risk subscribers, Blue Cross-Blue Shield will not be able to carry the "poor risks" because these "poor risks" are also in low income brackets and can't afford the necessarily higher premium. Leave these "low income, high risk" individuals unprotected against illness and we'll be right back where we started, only this time the socializers will be waiting with plans ready.

The effect on medical fees will be unfavorable to American Medicine unless Blue Shield obtains the contract since only through this organization can we wield influence in determining our economic status. Commercial insurance will provide fees in accordance with their projected profit percentage and these fees, by virtue of the tremendous number of persons involved, will exert a determining effect in doctors' charges.

It behooves physicians country-wide to support Blue Cross-Blue Shield to the utmost in their efforts to obtain this contract. Only by retention of such large and desirable groups in our own plans can we hope to forestall socialism.

Francis A. Barrett

☆ ☆ ☆ ☆ ☆ Presidential address*

John L. McDonald, Colorado Springs

I BELIEVE IN THE ANALOGY OF HISTORY. Today I want to review with you some medical history and then attempt an analogy which I confess may be too tortuous.

The physician whose medical teachings dominated medical thinking from pagan times well into the early middle ages was Galen. Galen was born in Asia Minor, whence came so much of our civilization. He died in 200 A.D., having done most of his work in Rome. He was not as great a physician as Hippocrates. He was boastful. His case records do not furnish the excellent clinical observations of Hippocrates and he rarely told of his failures. Nevertheless, he did incorporate much of Hippocrates' work in his teachings. Like Hoppocrates, he believed in the healing power of nature. That he was a good diagnostician can be illustrated by a case. One Eudamus, a philosopher, complained of a loss of sensation in the fourth and fifth fingers of one hand. Other physicians had failed to cure this by local treatment. In obtaining the history, Galen found that the patient had fallen from a chariot striking his neck against a sharp stone. This enabled him to fix the brachial plexus as the seat of the trouble, and following application of counter-irritants to this region the cure was achieved. The cure of course was probably achieved by time but that does not alter the fact that Galen made a logical diagnosis.

Anatomical inaccuracies

Galen's greatest contribution to medicine lay in his investigations rather than in his actual clinical work. He may be said to have been the first experimental physiologist. He realized that a knowledge of anatomy was essential to the study of medicine and the understanding of disease. Dissection of the human body was illegal in his time and his anatomy was based on study of pigs, dogs, and Barbary apes. He made the error of assuming and teaching that human anatomy was identical with the anatomy which he studied in those animals and in his writings it is not obvious that he is indeed describing animal instead of human anatomy. It would be 13 centuries before a far greater man than he would be able to deduce the reason for his anatomical inaccuracies and to correct them. He did, however, make some great discoveries. He knew something of the gross structure of the brain. He recognized seven pairs of cranial nerves. He distinguished between sensory and motor nerves and he discovered the sympathetic nervous system.

Medical knowledge retarded

He recognized that the arteries contained blood and not merely air as had previously been believed. He realized that the heart set the blood in motion but of course he did not achieve the idea of the circulation of blood. He believed that it ebbed and flowed in the vessels and his imaginative concept of the porous septum of the heart, stated with great conviction, was responsible for the maintenance of this fallacy for centuries.

He wrote a great deal, publishing probably 500 manuscripts of which 80 were preserved to be copied and recopied many times through the Dark Ages. Unfortunately, he affirmed that pus was "laudable" in wound healing, a belief which persisted to modern times. He also taught that surgery was merely a technical branch of medicine. This helped

*Presented before the 89th Annual Session of the Colorado State Medical Society, September 9, 1959, at Denver.

to keep surgery in a lesser role than medicine for centuries.

It would seem, however, on the whole, that Galen should be regarded as a great physician. Actually, he did far more to retard medical knowledge than to advance it. Because of the authoritative way in which he wrote, because of the continued objection to human dissection, because of the church's attitude toward scientific research and new ideas, Galen's teachings were held to be infallible and for centuries none presumed to question his authority.

Galen's teachings disputed

During the Renaissance, three great medical men dared to dispute Galen's teachings and each of them had to suffer persecution and villification by his contemporaries, little men who were not yet ready to abandon their devotion to the authoritarian.

Andreas Vesalius, foremost anatomist of all time, was born in Brussels in 1514. By the time he studied medicine, human cadavers were being used for dissection in Paris, which was his school. His teacher, Sylvius, expounded from Galen as Vesalius dissected. It was perfectly obvious to the young anatomist that the organs he was examining were not as described by Galen. For example, Galen said that the liver had five big lobes and yet in the human liver he could count but three large and two very small lobes. By dissecting dogs, pigs and apes he was able to discover the source of Galen's incorrect anatomical teachings. At the age of 23, he was appointed professor of surgery and anatomy at Padua. At the age of 28, he had dissected enough bodies and had learned enough anatomy to publish one of the greatest medical volumes of all times "On the fabric of the human body." The anatomical plates in this work were magnificent and the anatomical descriptions were revolutionary. The publication of this work should have brought him honor, fame, and the opportunity to continue his work in peace and with the help of eager students. Instead, it brought him persecution and abuse. His old teachers turned against him and even his students left him. All this because Vesalius had dared to question Galen. He was forced to give up his chair at Padua and he made no further contributions to anatomy.

Ambrose Paré, the greatest surgeon of the Renaissance, and in fact the first great surgeon, was born in France in 1510. He was apprenticed to a barber surgeon but soon succeeded in restricting his work to surgery alone. It happened that during his active career as a surgeon, France was engaged in many wars and Paré as a military surgeon had the opportunity to treat many wounds. These wounds were no longer the relatively clean wounds inflicted by the sword or arrow. Bullets did a great deal more damage to the tissue and to the blood supply, insuring a richer medium for the growth of germs. "Laudable pus" was present in nearly every case partly because further damage was done to the tissue by treating these wounds with boiling oil. Paré at first treated wounds in the traditional way but on one battlefield, when the supply of oil was exhausted, he applied to the wounds "a digestive of eggs, oil of roses and turpentine." Fully expecting that those patients would be worse or dead next day, he was astonished to find that they had little pain and that their wounds were not inflamed or much less inflamed than were those of the men treated with boiling oil. It would be centuries before the idea was universally accepted but for the first time since Galen, a physician had demonstrated that pus was *not* "laudable." He used ligatures to control bleeding because he found that the cautery was as harmful as boiling oil. He believed in cleanliness and so was a successful obstetrician. Soldiers blessed him but from his contemporaries and colleagues he received nothing but ridicule. The dean of the faculty of physicians at Paris published an angry tirade against the ignorant barber surgeon who dared to write in the vernacular and who dared to advocate new methods of treating wounds, hemorrhage, and even medical diseases. This tirade, however, was responsible for an amusing journal written in reply to the dean by Paré. In it he said, "Dare you teach me surgery, you who have never come out of your study? Surgery is learned by the eye and by the hands. You, my little master, know nothing else but how to chatter in a chair."

The third physician who rebelled against the authority of Galen was less great than

his fellows but in fact he used an even more dramatic way to show his contempt for Galen's system. Paracelsus was born in Switzerland in 1490 and studied medicine in Italy. As he studied from Galen's manuscripts he became more and more skeptical of their value. He traveled all over Europe, consorted with all sorts of people and observed the effects of many traditional folk remedies. After 10 years of wandering, he realized that he had correctly evaluated the worth or worthlessness of many types of medical treatment, herbal and chemical. He returned to Switzerland and there, before a lecture, he publicly burned the works of Galen, stating that "My beard knows more than you and your writers; my shoe buckles are more learned than Galen."

Inovators criticised

But medical authoritarianism was not yet ready to surrender to medical innovation. Three centuries later we can still observe the forces of reaction opposed to two great physicians, each of whom showed the contagiousness of puerperal fever. Our own Oliver Wendell Holmes logically deduced that it was the doctor with hands dirty from the dissecting room who scattered his cases of childbed fever here and there throughout the city in a fashion totally unlike the epidemic which spreads from door to door and neighborhood to neighborhood. He read his paper to the Boston Society of Medical Improvement in 1843 and met with nothing but abuse from the practitioners who considered that he had insulted them. Four years later, Semmelweiss in Vienna wrote that "puerperal fever is caused by conveyance to the pregnant woman of putrid particles derived from living organisms through the agency of examining fingers." When he had his students wash their hands in chloride of lime before examining these pregnant patients the mortality in his wards fell from 18 to 1 per cent. He gained one or two great supporters but almost without exception he was opposed and persecuted by the obstetricians of Vienna. He was forced to resign from his position and it is not at all unlikely that the villification he received contributed to his later insanity.

Pasteur was not a physician but his great work was responsible for one of the most brilliant chapters of our medical history. The story of the criticism which he received from the Academicians is well known. Lister, whose antiseptic system made possible surgery on any portion of the body and who must be ranked with Paré and John Hunter as the three greatest innovators in surgery, was for many years subjected to the same sort of treatment which had forced Semmelweiss to surrender. Lister was a strong man and he continued to work until the magnitude of his discovery could no longer be disregarded, even by the most vitrolic of opponents. Besides, about this time medical men were beginning to change their minds about medical innovators.

X-rays accepted

Already the value of the general anesthetic agent had been enthusiastically adopted and quickly after its discovery its use spread over the civilized world. A little later Wilhelm Roentgen announced the discovery of his astonishing "x-rays." The value of their practical application was accepted with unbelievable speed. Coming to our own time, we have seen the acceptance of insulin in the treatment of diabetes with scarcely an old fashioned dissent and this was also true of the dietetic treatment of pernicious anemia. Very little skepticism was manifested regarding the role of vitamins in specific diseases and none at all regarding the value of antibiotics.

Changing times

We have seen, therefore, that over the centuries our profession has been inclined to accept conventional ideas as fact and to resist new ideas vigorously. Social and economic ideas throughout the world are changing rapidly. The desire for self-government is increasing among people previously ignorant and subservient. Even among the long civilized Western nations the changes are dramatic. In our own field of medicine, social and economic ideas are subject to the same revolutionary pressures which characterize man's other social relationships.

I believe in the free choice of physician but I concede occasional instances in which it may be impossible to adhere rigidly to this

system. Do we weaken our position by making a shibboleth of this phrase? I think so. Who is there among us who does not believe in compulsory vaccination, compulsory regulation and purification of water supply, compulsory sanitary sewage disposal? If a new plague, a new Black Death appeared, would we not submit to quarantine and whatever other regulations seemed advisable until the danger of contagion diminished? Is not this an inconsistency in our firm belief that the individual is free to choose his own way to health?

Shades of grey

The American Medical Association at its meeting in Atlantic City this summer has maintained its belief in the advantage to patients and physicians of the principle of free choice of physician. I hope we may always be able to maintain it, but I would dislike to think that we considered it an absolute law for all time. In the same meeting, it was reaffirmed that many third party plans are necessary and in some cases desirable.

Many newspapers interpreted this as a change in policy of the A.M.A. I feel that some physicians had the same reaction.

Actually this has been the American Medical Association philosophy for a good many years. Does it seem to some a compromise of our principles? If so, then I believe such compromise is more beneficial to our patients and to ourselves than a rigid, unyielding insistence that there never can be an intermediary between patient and physician. Then, indeed, we might find forced on us a system of medical care over which we had no control.

We are unanimously opposed to state medicine. I have heard many among us here affirm that we must fight for our principles in this regard and not concede a single step of deviation from what we regard to be right, but how can we be certain that our social and economic ideas are entirely correct when all of our medical history proves that changing ideas are as likely or more likely to be right than the old ideas which they are displacing? Can we be certain that all our social and economic ideas are like the anatomical version of Vesalius on dissecting the human cadaver rather than like the erroneous ideas of Galen based on the anatomy of animals? Things are not always all black or all white. It is a truism that we must learn to accept that varying shades of grey also exist.

The danger of political intervention, of the introduction of state medicine, is due to the number of people eligible for some form of government social security, and I use the word "social" in its broadest meaning. Its prevention, however, lies wholly with us. We must, for example, recognize the peculiar problems of aging with unemployability which have greatly changed in the past few decades because of our own advances in medicine and in public health.

Through Blue Shield and Blue Cross we have made possible one of the most effective methods for maintaining the type of private practice which we believe in, the free choice of physician. Let us be certain that some shortsighted or selfish among us are not endangering these plans or if these plans become obsolete, let us be sure that they are replaced by sound ones. Are we permitting self-interest to interfere with essential actuarial requirements in these plans? I hope not, but it requires eternal vigilance on the part of our excellent Blue Shield Advisory Boards together with the skill of our professional lay Blue Shield and Blue Cross directors to maintain the efficacy of these plans. This is but one of the ways by which we attempt to maintain our tradition of private practice and free choice of physician. Many known problems have to be met. Many future problems as yet undreamed of will have to be met with common sense and proper flexibility of mind.

Humantarianism

Finally, I would like to pay tribute to all the members of our profession who have gone before us. During the whole period of recorded medical history, it is obvious that our goal is the alleviation of suffering. Service to the unfortunate has been our noblest objective since the time of the first great physician whose humanitarianism is preserved and remembered in the Oath of Hippocrates which we all take figuratively if not literally. During the centuries there have been exceptions, but in general all medical knowledge has been freely circulated so that all people

might take advantage of it. While others have perfected instruments for destruction, our aim has always been the eradication of disease and the prevention of suffering. No other profession, no other branch of learning, can demonstrate any such continuous regard for the welfare of mankind. •

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Glomus tumor of the leg*

A case report

W. E. Hess, M.D., Salt Lake City

This rare but painful growth, usually found in a subungual location, in this case went undiagnosed for one year because of its presence in the knee.

GLOMUS TUMOR[4,5], also masquerading under the names of angiosarcoma, perithelioma, painful subcutaneous nodule, glomangioma, subungual tumor, hemangiopericytoma[3], and angioneuromyoma, is a relatively rare condition even when found in its usual subungual location. It is even more rare when it involves the leg as in the case here to be reported.

The glomus is a specialized arteriovenous anastomosis surrounded by large, pale cells (glomus cells), between which are numerous, firm, medullated and non-medullated nerves. It is most abundantly present in the region of the nail bed, the tips of the fingers and toes, and the palmar surface of the phalanges. The tumor which springs from it is, therefore, most common in these sites, but it may occur anywhere in the upper and lower limbs, although not on the trunk. The function of the glomus is supposed to be concerned with heat regulation, the large vascular channels of which it is composed being under the influence of the abundant nerve supply.

The glomangioma, a perfectly benign and circumscribed tumor, blue or reddish in color, and seldom exceeding one cm. in diameter, is merely an enlarged glomus. It consists of tortuous vascular channels in the walls of which the smooth muscle has been replaced by large, pale cells of the epithelioid type, with clear or vacuolated cytoplasm. The cells may be clumped in large masses without a definite lumen. Sometimes plain muscle fibers intervene between the lumen and the mantle of epithelioid cells. These epithelioid cells, indeed, are supposed to represent altered muscle fibers. Abundant nerve endings are seen between the epithelioid cells, and it is pressure on these endings which is responsible for the pain that is so characteristic a symptom. In a considerable number of cases, the appearance of the tumor is preceded by a single severe trauma.

The clinical symptoms are highly characteristic and remarkably severe for so small a lesion. At first there are attacks of pain, limited to a small area, although no lesion may be visible. Gradually the attacks become more severe and are stabbing or burning in character. The pain, which may be radiating and neuralgic in character, may be spontaneous or may be produced by the slightest pressure. It is probably caused by the dilated glomus vessels pressing on the numerous nerve endings. Removal of the

*From the Department of Orthopedic Surgery, Salt Lake Clinic, Salt Lake City, Utah.

tumor is followed by complete and permanent relief. No minor operation wins a greater share of the patient's gratitude[6].

A search of the literature reveals one case in a 55-year-old man with a one cm. lump over the tibia, eight inches below the knee[1]. Karem Singh of India reported three glomus tumors around the knee in three patients and, in one patient, four tumors on one thigh[2]. I am certain there are other examples in the literature but they are difficult to find, and for this reason the following case is reported:

CASE REPORT

Mr. J. S. W. was first seen at the Salt Lake Clinic May 2, 1955, with the chief complaint of pain in the left knee of over one year's duration. He described the pain as stinging and burning and stated that even slight bumps and pressure of bed covers aggravated it. He had been a painter, but for the past six weeks he had given this up, since bumping his knee on the rung of the ladder caused pain of a severe degree.

Prior treatment in San Diego had consisted of multiple intra-articular injections; four x-ray treatments at three-day intervals, completed three weeks prior to my examination; much advice as to the use of heat, and local novocain injections. None of these had helped. The patient stated that his doctor was on the verge of referring him to a psychiatrist because of failure to obtain relief from pain and that he (the patient) had reached his wit's end, being unable to work and finding it extremely difficult to sleep.

Past history: The patient had had excision of a torn medial meniscus in the same knee in 1929, following a twisting injury one year previously. He denied any other operations or serious illnesses.

Examination: The patient was a well-developed, well-nourished 52-year-old white male of English extraction, who looked at least ten years older than his given age. He was noted to have rachitic bowing of both tibiae, worse on the right. There was epilation involving the entire left knee region from the junction of the middle and distal thirds of the thigh to the junction of the proximal and middle thirds of the leg. This was thought to be secondary to radiotherapy. There was a palpable, visible, slightly-mounded area over the anteromedial proximal tibial region on the left about the size of a 50-cent piece. This area was exquisitely tender to pressure with the tip of a lead pencil directly over the center of the enlargement. The tenderness seemed to be in the skin, since raising the skin and displacing it to one side revealed no deep tenderness. There was a very slight bluish stain, visible only in bright light, approximately the size of the tip of a lead pencil, at the most tender area. Range of motion of the knee was full and painless with normal stability, and no tenderness or swelling of the joint was noted.

X-ray examination: AP and lateral views of the knee and proximal tibia were negative except for a small spur on the inferior aspect on the patella.

The clinical impression was possible glomus tumor and the patient was admitted to the Latter-day Saints Hospital May 5, 1955. On the following day, the lesion was completely excised.

The pathologist's report was as follows: The specimen consisted of an elliptical wedge of skin measuring 3½ cm. in length and 1½ cm. in width. Subcutaneously, in the central portion of this wedge of skin, there was a small pink elevated mass of tissue measuring 3 mm. in diameter. This was firm and imbedded in the subcutaneous tissue and fat. Microscopic examination revealed a well-circumscribed glomangioma in the epidermis of the excised skin. This ovoid concentration of benign cellular elements had a definite perithelious arrangement with small capillaries and larger vessels. Around the margins of the tumor a few small nerve fibers could be identified by their sheath cells. Histologically, the tumor was made up of two or three patterns of cells, these cells varying in type and size. The cells that were arranged in perivascular mantles were very small and had little cytoplasm. Another intermediary sized cell was seen in a few areas, but distinctly larger cells had rather abundant acidophilic cytoplasm. These latter cells were arranged in ovoid clusters and sheaths. There was no evidence of malignancy.

The patient was discharged from the hospital on the following day and had an uneventful convalescence. He returned to his home in San Diego ten days postoperatively, after removal of the sutures. He resumed his work as a painter one week after returning to San Diego and has remained entirely pain-free and a grateful patient to this date.

Summary

A brief description of a glomus tumor, a review of the literature on the subject and a report of an interesting case involving the region of the knee has been presented in the hope that it will help others to be cognizant of this lesion when faced with a similar set of signs and symptoms. •

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Immediate postoperative problems*

Charles B. McCrory, M.D., Denver

Vomiting and hypoxia or both are the major problems of the anesthetized patient after surgery.

ALL ANESTHETIC PROBLEMS which appear in the immediate postoperative period are actually the culmination of a series of events which preceded or occurred during the administration of the anesthetic. Theoretically, if the anesthetist has been cognizant of these apparently insignificant events, and recognizes their meaning, and if he has had both the time and means for remedial action, there are no postoperative problems. Thus, the anesthetist must constantly anticipate the ultimate result of every one of his actions as concerns that particular situation and patient.

Nausea and vomiting

Nausea and/or vomiting is the patient's most common worry second to the natural apprehension concerned with any surgical procedure. It should also be our primary worry as the 1956 report by Edwards indicates. Vomiting was implicated as the cause of death in more than 10 per cent of the 1,000 cases being reported, and among the obstetrical deaths associated with anesthesia over half were directly related to vomiting. This group, as we all know, is notorious for going into labor with full stomachs. However, this report should reinforce our suspicion that every patient we anesthetize is going to vomit, and since we are the ones who remove the normal protective reflexes, it is our responsibility to supply that protection.

By what means can we reduce this problem to a minor status? First, by obtaining a careful history as to what foods and liquids have been taken in the preceding 24 hours; by determining the time relationship between eating and the accident or illness and the proposed surgery; knowing the kind and content of the vomitus if it has occurred; knowing the means employed to obtain an empty stomach prior to surgery. Second, a careful evaluation and if possible a confirmation of the history as given. Third, the correction of any omission which casts doubt as to whether the stomach is truly empty.

Assuming the stomach is full prior to the time of surgery, what should be done? The temptation is to crash full tilt: a shot of pentothal, a shot of Anectine, and rapid intubation. However, whenever the patient is asleep enough or relaxed enough for intubation, the cardia of the stomach is also, and the first sight of the larynx with the laryngoscope may be through a pool of fluid. A better technic is to inform the patient that a full stomach is a hazard and that in his best interest you plan to empty it. Plan A might be the time-honored finger-down-the-throat method. Plan B might be swallowing a teaspoon of tartar emetic in warm water.

continued on next page

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Plan C might be 2-5 milligrams of apomorphine given intravenously. Plan D might be the naso-gastric tube plus suction. Plan E might be to delay surgery another four to six hours and hope that with the patient N.P.O. and sedated with narcotics and belladonna drugs, the digestive mechanism might proceed normally. Actually none of these plans are good.

Intubation

The best plan for the patient that has recently eaten is to inform him that it is necessary to intubate him awake. To anesthetize the oropharynx, larynx, and trachea is simply and quickly done and the patient can be intubated gently with no untoward complications. The choice of anesthesia from that point on makes no difference.

When the patient begins to emerge from anesthesia, several stimuli must be avoided; the too rapid removal of an endotracheal tube; too vigorous suctioning of the pharynx; too roughly moving the patient from table to cart or bed; the centrifuge effect of swinging a patient around a corner; the bouncing and jolting of carts with flat wheels, or floors with many cracks and buckles. These stimuli may be local or may have an effect centrally.

Since we cannot always avoid vomiting, what steps should be taken to protect the patient who does? Instead of the standard face-up position in bed or on a cart, I recommend strongly the lateral or tonsil position with the head a little lower than the feet. This position permits good drainage of secretions or vomitus from the oropharynx and facilitates maintenance of an airway. The protection of the airway is the main factor in our worry about vomiting, it is not the mess or content itself.

In the lateral position a patient can be given the same complete care that occurs when he is face up. He can be given oxygen by catheter or mask, suctioned, catheterized, turned, coughed, checked for vital signs, or given an intravenous medication with no more difficulty than usual. Also most patients as they arouse from the anesthetic sleep usually try to turn on their sides, and this is frequently the signal for someone to give a hypo of one drug or another for pain or restlessness. This knocks the patient out for another couple of hours and everyone is happy (and ignorant).

Hypoxia

Involved with and probably most frequently a cause of postoperative vomiting is inadequate ventilation during the preceding anesthetic or immediately afterward. Here lies the patient with all the symptoms of mild to severe hypoxia. Early hypoxia is manifested by restlessness, nausea, dizziness, weakness, and increased respiratory effort. Later, the symptoms progress to include vomiting, tachycardia, muscle incoordination, mental confusion, and rising blood pressure. Still later, gasping, unconsciousness, slow bounding pulse which becomes irregular and weak, then falling blood pressure, respiratory and circulatory arrest.

Unfortunately, the treatment for these early signs may be in the form of a hypo designed to depress the patient even more, instead of clearing the airway which is partially or even totally obstructed, or improving the ability to ventilate by anti-curariform drugs, or even improving the oxygen content of the atmosphere that the patient is trying to breathe. Time is the anesthetist's greatest friend or enemy, depending on the circumstances. Time is an enemy when three minutes without oxygen is approaching, or circulation is stopped. It is a friend when adequate ventilation is removing a gaseous anesthetic, or a parenteral medication is being metabolized in a straight forward fashion. However, even friends may be inconvenient to our plans occasionally; such a time might be as we assist the patient's breathing following a relative overdose of relaxing agents or anesthetic agents which are still effective after the surgeon is finished.

Summary

The statement is still true, if the anesthetist is vigilant and anticipates his actions at all times, there will be no immediate postoperative problems. •

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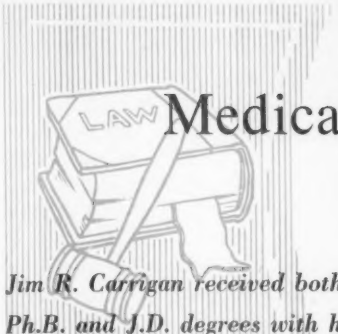

Medical malpractice in Colorado*

Jim R. Carrigan, Denver

Jim R. Carrigan received both his Ph.B. and J.D. degrees with highest honors from the University of North Dakota in 1953. He has been a visiting Assistant Professor of Law at New York University, which granted him the LL.M. degree in Taxation. Since early 1957 he has been an Assistant Professor of Law at the University of Denver, and faculty editor of DICTA. He recently resigned to associate himself with the University of Washington School of Law at Seattle.

ACCORDING TO A RECENT ESTIMATE the cost of judgments, out-of-court settlements, investigation expenses and legal fees paid in malpractice cases by the American medical profession and their insurers now exceeds $45,000,000 each year. This estimate would indicate that malpractice claims are far more prevalent and judgments recovered are far larger in other parts of the country than in Colorado. Just how prevalent are these claims? The American Medical Association has reported that about 14 per cent of all its members in the United States have been subjected to such claims. In California, where the claim rate seems to be the highest, one doctor in every four has been charged with malpractice.

No doubt the average doctor upon first hearing of a malpractice claim against one of his colleagues is tempted to damn the claimant's attorney. But contrary to the opinions of most medical men, attorneys very seldom if ever are the initial instigators of medical malpractice claims. In fact, a renowned and highly respected physician who claims many years of "wide experience advising doctors, helping defense attorneys, appearing in court . . . as an expert witness, and as a defendant . . .," recently declared: "My observation has been that *every* malpractice suit, *without any exception*, is instigated either directly or indirectly by a doctor."

Unquestionably some malpractice claims are without foundation in fact or support in law. Just as unquestionably some malpractice claims are well founded in both fact and law. It is the ethical obligation of every attorney to discourage groundless claims and not to espouse unjust suits. It should be the ethical obligation of every fair minded physician to cooperate in obtaining justice for a patient who has been wronged by a fellow physician. The overriding duty of each profession is to the public. The problem of both groups is to determine which claims are justified and which are not. Since fair evaluation of claims can best be accomplished through understanding of the law governing them, this paper surveying, summarizing, and criticizing the sizable body of Colorado case law in the field is submitted in the hope that from increased knowledge will grow greater mutual understanding between our brother professions.

Theory and nature of the action

At common law an action for negligent treatment by a physician generally was insti-

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Since litigation and threats of litigation for alleged malpractice have become a national problem, this article is both enlightening and helpful to every practicing physician. It represents exhaustive research on the part of Professor Carrigan. A list of 235 references has been deleted because of space limitations.

tuted by a writ of trespass on the case. The older action in trespass was unavailable in most cases because almost always the patient had consented to the touching of his person and therefore he could not plead a direct, forcible trespass. But in cases where treatment was instituted without consent of the patient or continued against his will after he had discharged the physician, the doctor's touching or cutting of the patient's body might constitute trespass in the nature of battery or both assault and battery. Moreover, where the patient's consent was limited to a particular treatment or operation and the doctor went beyond that treatment or performed some unauthorized operation, there might be a trespass action. Finally, there was sometimes available, as an alternative, an action in assumpsit based on breach of the physician's express contract to effect a cure or upon an implied contract to use due care in treatment. Sometimes a single act might subject the practitioner to an action in trespass, case (negligence), or contract, at the option of the claimant.

Abolition of common law pleading and of forms of actions has not eliminated the practical value of understanding these distinctions. The theory of the case is still highly significant. One must still plead facts which would have allowed a recovery on *some* theory under the prior practice. Furthermore, the theory of the action may determine what statute of limitations governs it, whether the plaintiff must prove actual damages to get his claim to the jury, whether punitive damages may be recovered, whether damages are limited to those within the contemplation of the parties when the relationship was entered, whether the action survives death of a party, whether release of a prior tortfeasor releases the physician called to treat injuries caused by that tortfeasor, and whether malpractice insurance covers the claim. Most of these problems have been dealt with in Colorado cases. This article will be limited to actions on claims for breach of contract, assault and battery, and negligence.

BREACH OF CONTRACT

It is fundamental that in the absence of an express contract to the contrary a physician by undertaking treatment in a particular case does not warrant a cure or even an improvement in the patient's condition. The law recognizes that many of "the thousand natural shocks that flesh is heir to" are incurable, and that intervening causes quite unrelated to the physician's ministrations "may sometimes thwart the highest skill employed in the accustomed or only procedure known."

But Colorado cases often have declared that a physician when employed impliedly contracts: (a) that he possesses a reasonable degree of learning and skill equal to that ordinarily possessed by others of his profession, (b) that he will utilize reasonable skill and observe ordinary care and diligence in exercising his art and applying his special knowledge to accomplish the purpose of his employment, and (c) that in diagnosing the disease or injury and selecting the mode of treatment he will employ his best judgment. Thus it is theoretically possible that his failure to perform these implied promises will give rise to a breach of contract action. This possibility is recognized in the statute of limitations on medical malpractice which is expressly made applicable to actions based on implied contract. A survey just completed by the American Medical Association's legal division indicates that among those who file claims against doctors, "suing for breach of contract has become more popular." However, this theory of action has seldom been utilized in Colorado.

Besides the possibility of *implied* contract, it is possible that a particular physician may at the time of employment promise to effect a cure or improvement and thereby create an *express* contract. Even if such representations were considered ethical, no wise practitioner would indulge in them, for such an agreement would render him liable without regard to fault if for any reason his treatment did not achieve the promised results. There may be a danger that in attempting to quiet a patient's fears or to reassure him, a doctor, without intending to guarantee a cure, might make remarks which the patient could reasonably interpret as such a guarantee. In such a case it is possible that a court might find a contractual obligation. The dangers to the doctor from such unintended contractual entanglements are magnified by

the fact that many medical malpractice insurance policies probably do not cover liability of a doctor for failure to perform his contract to accomplish a cure or improvement of condition.

ASSAULT AND BATTERY

Colorado case law indicates that a physician who treats or operates upon a patient without the latter's consent may be liable for assault and battery. Other jurisdictions have held that a surgeon who has the patient's consent for a particular operation but goes beyond that consent to perform other or additional surgery is guilty of an assault and battery. Colorado has rejected the latter position, at least for purposes of holding the one year limitation on assault and battery actions inapplicable to such a case.

From the plaintiff's point of view this theory of action has certain distinct advantages. In such a case the doctor could be held strictly accountable for an unfortunate result without proof that he was guilty of the slightest negligence. In many cases the plaintiff by choosing this form of action would by-pass the hurdle of obtaining expert testimony to prove negligence. Moreover the law presumes that at least nominal damages flow from every assault and battery, and the plaintiff could get his case to the jury without proving any actual damages. Exemplary damages would be possible, since assault and battery are intentional torts.

At least two factors discourage this form of action. First, a recent survey indicates that some medical malpractice insurance policies may exclude coverage of intentional torts generally or of treatment without consent, and furthermore exemplary damages are not covered by liability insurance. Second, a special one year statute of limitations probably would apply to some malpractice actions brought on this theory in Colorado.

For the physician seeking to avoid assault and battery claims, the practical problem is what constitutes a sufficient consent to authorize treatment or surgery. Apparently Colorado law prescribes no technical requirement of a written, signed consent, even for serious and irreversible surgery. But a clear, specific, written and *signed* consent from an informed and understanding patient, or one authorized to consent for him, can be a most effective lawsuit preventive. One who relies on a patient's oral consent may find himself trying to convince a jury that the patient did consent, or that the operation performed was the one requested. Failing that, he may be held liable even if the operation was done in the most careful and skillful manner possible. Even worse, he may have to pay any judgment personally since, as has been noted, his malpractice insurance may not cover the battery involved in an operation without consent.

No prudent surgeon should wield the scalpel without personally examining a properly signed consent form which clearly authorizes him to perform a particular operation on a named patient. He should be chary of relying on the assurances of others that proper consent forms have been executed and filed. In addition to written authorization to perform the particular operation contemplated, it is often advisable to obtain the patient's general consent to perform other or further surgery whose need becomes apparent only after the patient is unconscious and the incisions for the intended operation have been made. While it is true that courts generally are liberal in holding that an unconscious patient's consent to surgery reasonably required to prevent death or serious harm is assumed, there is no direct Colorado authority recognizing this legal fiction, and there is respectable non-Colorado authority severely limiting it.

A closely related problem is *who* may consent on behalf of another. While a parent may consent for a child of tender years, and a spouse for an incompetent or unconscious husband or wife, generally a mentally competent adult, whether man or woman—married or unmarried—is master of his own person and is the only one capable of consenting to an operation on that person. On this point the Colorado *Smith* case seems to reach a highly questionable result. There the husband-patient claimed that the only operation he ever discussed with the defendant doctor was a circumcision. The defendant testified that the *only* conversation he had with the plaintiff prior to the day of the operation was a consultation in which he, the defend-

ant, recommended a circumcision. But, said the defendant physician, "all subsequent discussion, including arrangements for, and instructions relative to, the operation, were made by him with plaintiff's wife, mostly by telephone." The plaintiff agreed that "his wife did most of the talking . . ." and admitted that when the date for the operation was set, he, the plaintiff, did not clearly request the circumcision previously recommended. "Defendant . . . further testified that when plaintiff's wife called him to make definite plans for the operation he asked her what operation, whether circumcision or sterilization, to which he referred, because of Mrs. Smith's apparent difficulty in understanding what he meant, as the 'tube-tying' operation, and that she replied that was the operation to be done."

The best that can be inferred from this evidence is that in performing an operation upon *Mr.* Smith the physician relied upon *Mrs.* Smith's choice of the operation to be performed even though she was apparently having difficulty in understanding what operation was being discussed. Inescapable is the conclusion that *Mr.* Smith, who was sterilized, never at any time *personally* consented to be sterilized. Yet, the Supreme Court reversed the trial court action in directing a plaintiff's verdict on liability and held that this evidence presented a jury issue whether the plaintiff had consented to the vasectomy.

Generally speaking it is prudent procedure to obtain the consent of both husband and wife if either is to be sterilized. But if the *Smith* case be law in Colorado, a doubtful hypothesis, it is not necessary to obtain the consent of the husband, but only of the wife, if the husband is to be sterilized. Happily for the male animal and for unborn generations, the case is unique and probably will never be followed on this point.

NEGLIGENCE

The theory by far most important, because nearly all medical malpractice cases are based upon it, is negligence. Because of its paramount significance, a major portion of this paper will be devoted to the negligence theory.

Negligent malpractice

Those who engage in the healing professions, no more nor less than other men, may be liable in tort for damages caused others by their negligence. It has been said that: "Negligence in actions of this nature is no different than in other situations. It consists of doing something, which, under the circumstances, should not have been done, or in omitting to do that which should have been done." While this generality is not untrue, it is incomplete. Medical malpractice law, although it is but an application of general negligence principles in a specific frame of reference, presents some special legal problems. Problems concerning the standard of care imposed upon practitioners, the specific acts or omissions which may be deemed negligence, and the burden of proving negligence in this kind of case are of particular significance. These problems will be discussed separately in the order indicated.

THE STANDARD OF CARE

Generally speaking, negligence is conduct which falls below a standard established by law to protect others from an unreasonable risk of harm. A doctor, like any other man, may be liable for injury to another proximately caused by his "failure to exercise that degree of care, prudence and forethought, which an ordinarily careful and prudent person would exercise under the same or similar circumstances." This standard governs the physician as a man in his non-professional contacts with other men.

His conduct in the capacity of doctor is another matter. In addition to the minimum standard which all men must meet, men who hold themselves out to the public as having special skill, training and knowledge in a particular profession must meet a higher standard imposed only on those who follow that profession. The special standard imposed on members of the medical profession has been oft repeated in Colorado cases.

In a 1957 case the Supreme Court reaffirmed its adherence to the long established standard that, "A physician is bound to accord his patients such reasonable care, skill and diligence as physicians in good standing in the same neighborhood in the same gen-

eral line of practice ordinarily have and exercise in like cases."

Earlier Colorado cases had not restricted the standard to the *same* neighborhood, but had measured a defendant's act by whether it would have been considered good medical practice in the *same* or *similar* localities. The distinction might have practical importance in a case involving conduct of a doctor practicing in an area where all doctors have been negligent in keeping abreast of developments in the profession. That others also are negligent is not ordinarily a defense.

The trend of later cases from other jurisdictions is to recognize as too narrow the standard of the "same locality" and substitute the phrase "the same or similar localities." This broader rule may work to the advantage of a physician charged with negligence for using a treatment not in general use in his own community. He may be ahead of his fellows in adopting a new development already proven through wide use in *similar* localities. Such leadership should not be considered negligence.

Nevertheless the law continues to take into account the differences in opportunities and facilities in dissimilar communities and recognizes that the country doctor cannot be held to the standard applied to him who practices in a metropolitan medical center. So too the law recognizes that a general practitioner cannot be expected to have as much skill or knowledge as a specialist.

In some cases the plaintiff admits that the defendant doctor was both careful and skillful in carrying out the treatment given, but claims that he was negligent in the first instance in *choosing* the wrong treatment procedure. In such a case the key issue of negligence depends on whether the treatment selected was one which reasonably skilled, prudent and careful practitioners in the same or similar localities would have approved for the plaintiff's ailment. Only expert testimony can establish this standard.

The last mentioned standard applies only to negligence in the choice of treatment for an ailment whose proper treatment is well established among medical men at the time the defendant acts. Where the medical authorities are not in accord on the proper treatment or where no effective procedures have been proven by legitimate experimentation, the physician is free to exercise his own judgment. With wise restraint, the law refuses to interfere with that judgment, lest physicians be deterred from exerting their best efforts in doubtful cases. An 1895 Colorado case stated the rule, which is still good law, that, "in a case involving doubt, or when there are reasonable grounds for a difference of opinion as to the nature of the disease and the proper mode of treatment, if a physician or surgeon possessing the requisite qualifications applies his best skill and judgment, with ordinary care and diligence, to the examination and treatment of a case, he is not responsible for an honest mistake or error of judgment as to the character of the disease or the best mode of treatment." This is a sensible rule and one which avoids imposing on physicians a stricter standard of liability than that imposed on other professional men.

In interpreting the rule concerning errors of judgment, the Colorado court has been most reluctant to second-guess the physician and most lenient in giving him the benefit of the doubt. For example, in a 1937 case where five physicians condemned the procedure followed by the defendant, but ten others approved it, the high court reversed a jury verdict for the plaintiff and ordered a non-suit without a new trial. It would seem that in such a case there is at least a question of fact for the jury, especially when one considers how difficult it is to get even one physician to fully express his real feelings in an action against another doctor. Whether the present Supreme Court would be inclined to take such a case from the jury is at best a matter of conjecture.

Honest mistake of judgment is available as a defense only if it appears that the physician used reasonable care in exercising that judgment. One who has the utmost skill and learning may nevertheless be liable if he fails to apply his ability in gathering facts on which to base a judgment of the treatment to follow. Whether reasonable care is employed in exercising judgment is usually a question of fact for the jury.

The rule restricting medical practitioners to the use of proven and generally recognized methods of treatment is intended to protect

the public against injury through unwarranted experimentation with new methods and untried theories. At this point it is important to note two Colorado cases which espouse a novel test of negligence for cases where the treatment procedure is questioned. In *Brown v. Hughes* the 1934 court, without citing any authority, declared: "The defendants herein must first have left and abandoned all knowledge acquired in the fields of exploration and adopted some rash or experimental methods before they approached the danger zone of liability." In the court's words, the issue was, "Does the evidence here evince want of skill or a reckless disregard of consequences?" The error was compounded by repetition in another case three years later. In the latter case the court concluded that the jury had no right to find the defendant liable for a death following an operation condemned by five medical witnesses. Said the opinion: "The defendant did not undertake a wholly new experiment but, according to the evidence, followed a method that had previously been used with success by himself, and a procedure — admittedly rare--but known to have been sometimes used." Certainly the law should be reluctant to stifle new methods and improved treatments but the test laid down in these two cases requires that a plaintiff prove what is tantamount to gross negligence if not willful wrongdoing. Considering that in this kind of case the only proof acceptable must come from the defendant's fellow practitioners, the practical impossibility of meeting such a test is obvious. It is submitted that these two cases are without foundation in reason, policy or law and should be repudiated at the first opportunity.

In addition it must be borne in mind that in determining whether a particular procedure is medically approved, the question must be answered according to the tenets of the school of practice to which the defendant belongs. Under this rule an osteopath's procedures and treatments are to be tested against the standard of methods among osteopaths. It follows that what is negligence if done by a medical doctor may not be negligence when done by a chiropractor and vice versa. This is a judicial recognition that medicine is yet an incomplete science and no one school of practitioners has a monopoly on knowledge of effective treatment methods. Furthermore, one must not forget that methods forbidden by the standards in one type of locality may be quite acceptable in another. It should be noted, however, that the trend of later cases from other states is toward holding all who practice the healing arts close to the high standards of the medical profession proper. These cases reason that advances in medical knowledge, combined with tremendous improvements in communications media, make it easier for all practitioners regardless of locality or school of practice to have the minimum knowledge required to protect the public.

These standards of care can best be understood by considering instances where the Supreme Court has applied them to particular acts or omissions claimed to constitute negligence.

ACTS OR OMISSIONS CONSTITUTING NEGLIGENCE

It is of course elemental, in this context as elsewhere, that "negligence may consist of either wrongful action or wrongful inaction." Stated another way, a physician's negligence may consist "in his doing something which he should not have done, or in omitting to do something which he should have done."

Negligent omission. Plaintiffs in Colorado cases have alleged negligence through inaction in the form of failure properly to diagnose an ailment or injury, failure to x-ray where a possible fracture was indicated, failure to direct immobilization of a fractured limb, and failure, after setting a fractured bone, to use reasonable care to ascertain whether it has remained in proper position.

In one suit the claimant alleged, but could not prove, that the attending physician had been asked to bring a specialist into the case but had failed or refused to do so. A somewhat similar early case held that a physician called to treat the plaintiff for typhoid fever was not guilty of malpractice in failing to comply with the latter's request that an oculist be brought into the case to treat a serious eye condition, at least in absence of proof

that the typhoid fever had caused the eye ailment.

Occasionally, the threat of legal liability may interfere with good medical practice. Such an instance might occur where a physician decides that for medical reasons it would be better if the patient does not immediately realize the gravity of his condition. If the serious condition improves or disappears this will be considered good therapy. But if not, the doctor may be sued by an irate patient claiming that the condition was not diagnosed properly or that it was negligence not to fully inform him of the seriousness of his malady. Similarly it may be alleged as the basis of a claim that upon discharge the physician neglected to inform the patient that further treatment would be required. Courts in other jurisdictions have frequently stated "that the relation between the physician and his patient is a fiduciary one and therefore the physician has an obligation to make a full and frank disclosure to the patient of all pertinent facts related to his illness."

Negligent omission may involve occurrences having neither relation to nor bearing upon the physician's technical skill. Thus it is obvious negligence for a surgeon to allow an unconscious patient to roll off an operating table quite without regard to the standard of skill and care observed by the surgeon while actually performing the surgery. Likewise failure to take the minimum precautions necessary to assure that the patient gets the operation intended for him and not that requested by another would seem to present a clear case of negligence.

Finally, in the category of negligent malpractice by omission would fall the cases where it is charged that the patient's condition was unnecessarily aggravated or death resulted because of the physician's general inattention and failure to respond to urgent requests for aid. Although a doctor may have no legal duty to undertake care of a particular patient in the first instance, once he commences treatment he "cannot discharge a case and relieve himself of the responsibility for it simply by staying away without notice to the patient."

Negligent affirmative acts. Colorado cases have dealt with two distinct kinds of affirmative action constituting negligent malpractice. The first type consists of adopting a procedure or prescribing a treatment other than the procedures and treatments generally considered acceptable and effective remedies for the disease or injury involved. If an unproved or otherwise unacceptable method is chosen and injury results, the physician may be liable even though, once adopted, the procedure is carried out with the utmost care and skill. Thus a doctor who perscribed a poultice instead of the usual minor surgery was required to pay damages in spite of his plea that at most he was guilty of an honest mistake on a matter of judgment. Similarly, a surgeon and dentist who cooperated in administering a general anaesthetic to a patient known to have a weak heart and then extracted his tonsils plus 16 impacted teeth, failed to convince a jury they were not liable for the patient's death.

The procedure adopted must be appropriate to the case at hand, and thus the question of proper diagnosis may overlap the problem of choice of treatment. A method considered safe for removing foreign objects from the throat may not be approved for removing them from the esophagus. Measures effective for dislocated shoulders may not be advisable for fractured arms.

Whether a particular procedure or treatment is acceptable must be proved as part of the plaintiff's case and generally the only acceptable evidence is expert medical testimony.

In a second and more common form of malpractice by affirmative negligence, the negligence involved is not the adoption of an incorrect diagnosis or treatment but consists of performing an approved procedure in a careless or otherwise substandard manner. Thus where a physician in treating a fractured collar bone employed the proper method but so carelessly set the bone that the fragments overlapped causing a crippling deformity, it was held that a verdict for the patient was justified. This form of negligence may occur in diagnosis or in treatment. For example, in a given case proper diagnostic examination might justify use of an x-ray, but if serious burns result, a jury might conclude that the x-ray was improperly used.

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Colorado case law examples of affirmative negligence in treatment range from maladministration of drugs to tearing of the patient's esophagus while attempting to remove a bone lodged in her throat.

This type of affirmative negligence frequently occurs where an approved surgical operation is performed in a negligent manner. Thus where the surgeon performing an appendectomy severs the patient's intestine, or otherwise cuts or injures some part of the anatomy not properly involved in the intended operation, the negligence may sometime be obvious even to a layman and no expert testimony should be required to establish negligence.

Of like kind are the cases where surgeons have left foreign objects inside patients, cases once so numerous as to evoke from the Colorado court the comment that, "Their perusal would almost lead to the conclusion that certain surgeons use such incisions as waste baskets." In such cases also the negligence is manifest. Even proof by the defendant surgeon that a sponge count came out correctly may not be conclusive to clear him. It follows that if the surgeon had notice immediately following the operation that the sponge count did not check, his inaction thereafter would seem to constitute strong evidence of negligence.

One need not spend years in medical school or specialized practice to discern that in cases such as these somebody has been negligent. They are not unlike the classic Mississippi case where the court, with typical Southern reserve, declared: "We can imagine no reason why, with ordinary care, human toes could not be left out of chewing tobacco, and if toes are found in chewing tobacco, it seems to us that somebody has been very careless." To paraphrase, the layman can imagine no reason why, with ordinary care, sponges and surgical instruments cannot be left out of human beings, and if such foreign objects are found in a patient after an operation, it would appear that somebody has been negligent. This of course involves the very practical problem of the plaintiff's burden of proving negligence and the extent to which that burden may be lightened by the doctrine of *res ipsa loquitur*.

Burden and manner of proof

PROOF BY EXPERT TESTIMONY

In many medical malpractice cases the plaintiff has the burden of proving the standard of care as part of his case. If he fails to prove the standard, the case cannot go to the jury, for the jury will not be allowed to set up a standard of its own. This rule applies where it is claimed that the defendant has employed a treatment not generally recognized in the profession. Here the essence of the negligence is in deciding to do what was done, not in the manner of doing it, and obviously a lay witness cannot say whether doctors generally would react to particular symptoms by employing a particular procedure, operation or medication. In such cases, therefore, the standard to be applied by the trier of facts must be established by expert medical testimony, and cannot be otherwise established. Furthermore, if different schools of medicine recognize different standards or methods of treating a particular condition, the expert testimony required should come from adherents of the school which the defendant follows. Defendants should be careful lest in seeking to exculpate themselves by describing their usual methods and precautions they incidentally provide the plaintiff with otherwise unobtainable expert testimony establishing a standard.

Once the standard of care has been established by medical testimony, the plaintiff must produce evidence that it has been violated. If the case concerns a charge that the defendant engaged in a medically unacceptable procedure, the necessary expert evidence will often take the form of answers to hypothetical questions. For example, in *Dixon v. Norberg* the plaintiff claimed that her esophagus had been injured by the defendant's unorthodox procedure in trying to remove a pork bone which had lodged there. After the plaintiff testified describing her condition, the defendant's treatment procedure, and the resulting injury, the plaintiff's attorney called medical witnesses to establish that the defendant's procedure in the case constituted negligence. These medical specialists, "in answer to hypothetical questions, testified that, assuming the existence of a bone in the esophagus and a probing for

it in the manner related by plaintiff, such a procedure was not good practice considering the present standards in the profession for a general practitioner and would be dangerous to the patient." Similar procedure has been followed in other cases requiring expert evidence.

Occasionally the courts have mentioned the practical difficulties encountered by plaintiffs seeking expert testimony. It is natural for medical men, out of empathy or sympathy, to be reluctant to testify against a colleague embroiled in legal difficulties. But it is difficult to understand the usual explanation to the effect that a code of ethics forbids such testimony. For professional men whose first duty is to the patients they serve to refuse to testify fully and frankly in order to right a wrong against one of those patients is bad enough. But to so refuse on the ground that to tell the truth would be unethical compounds the original wrong and perverts the meaning of ethics. No self-respecting lawyer seeks from any witness, medical or otherwise, anything but the truth. No self-respecting doctor should suppress the truth, even if it happens to be evidence in a lawsuit against another doctor. In the long run the "conspiracy of silence" among medical men will hurt them far more than it will help them. This is already obvious in the form of judicial departures from the once universal rule requiring expert testimony to establish negligence in a malpractice case.

PROOF WITHOUT EXPERT TESTIMONY

All too often attorneys, frustrated by the near impossibility of obtaining medical testimony to establish the standard of care and the fact of negligence, advise against pursuing a well founded claim or settle for far less than the case is worth. This may be a mistake. There is abundant Colorado authority recognizing that in certain types of medical malpractice cases no expert evidence is required to establish negligence. Only where the negligence charged is that the defendant treated the injury or disease by a procedure or operation not acceptable to his own school must the standard of care be established solely by medical testimony.

On the other hand, where it is alleged that a procedure admittedly proper for the ailment involved has been negligently performed, and the matter under investigation is so simple that laymen as well as experts can understand it, negligence may be established without medical testimony. Indeed, it may even be error to admit expert testimony in some cases of this nature. Thus where an oral surgeon continued to operate after profuse bleeding had blocked his vision, and he accidentally severed a nerve, it was held prejudicial error to instruct the jury that only expert evidence could be considered in determining whether the defendant had been negligent. Again, where an osteopath treating a stiff neck employed the procedure generally approved by osteopaths, i.e., manipulation, but applied force so great that paralysis immediately resulted, it was not necessary for another osteopath to explain to the jury that there may have been negligence.

In cases where it is possible to prove negligence without expert testimony or by a combination of expert and lay testimony, the quantum of evidence necessary to take the case to the jury is no greater than in other kinds of cases. Any pertinent evidence having a fair tendency to sustain the alleged negligence will suffice for this purpose.

However, it has long been established that mere proof that the patient died or that the treatment failed is no evidence whatever of the physician's negligence. This follows from the previously discussed rule that in absence of expression contrary, a physician does not warrant a cure or favorable result. Thus it has been held that proof that an injured limb is defective after treatment is not evidence of negligent treatment. Nor was the death of a cardiac patient following a combined tonsilectomy and wholesale extraction of teeth considered evidence of negligence.

Occasionally, even in cases where it would seem to the layman that the injury could not have occurred in the ordinary course of events without negligence, the Colorado court has required a high degree of precision and detail in the plaintiff's evidence of negligence. This reached an extreme in the 1953 case of *McBrayer v. Zordel*. There a four-year-old girl sued a surgeon and anesthetist for loss of four teeth knocked out during a tonsilectomy. The plaintiff's evidence includ-

ed testimony that immediately prior to the operation the teeth had been sound and strong. This the surgeon admitted. In addition the plaintiff's mother and father testified that immediately after the operation the surgeon and anesthetist had placed the blame for the occurrence upon each other. At the trial both doctors denied this and each claimed he had no idea how the teeth had been loosened. For the defendants, 10 experts testified that during such operations baby teeth are often knocked out even though reasonable care is used.

The trial jury found for the plaintiff, but on writ of error the Supreme Court not only reversed but ordered the complaint dismissed. This disposition of the case was based in part upon the Supreme Court's view that there was no evidence of any negligence to take the case to the jury. Said the court, "it was not shown by any evidence *exactly* how the incident occurred, and neither of the operating doctors seemed to know, but said that without any apparent cause or reason, it happened frequently in such operations." Such a result is quite acceptable to anyone willing to suppose that four firm and healthy teeth (not properly involved in any operation) are quite likely to drop out of a child's mouth simultaneously and of their own accord while the child is lying immobile. That supposition is as reasonable as expecting a four-year-old child who was unconscious at the time of the occurrence to describe in detail "exactly how the incident occurred . . ." when two physicians who were present, conscious, and presumably attentive claimed they didn't know how it happened. In a not dissimilar leading California case where five doctors and hospital personnel were present when a patient rendered unconscious for an appendectomy somehow received a shoulder injury, and all five were unable or unwilling to explain how the injury occurred, all were held liable. Thus did one of the nation's leading courts express its exasperation at the "conspiracy of silence."

Happily the present Colorado court does not seem to require detailed evidence of specific negligent acts in similar cases where a layman is justified in inferring from the result that someone must have been negligent.

RES IPSA LOQUITUR

Any meaningful discussion at this date of the Colorado *res ipsa loquitur* doctrine must begin and end with the truly remarkable 1958 case of *Weiss v. Axler*. Although not a medical malpractice case, *Weiss'* broad interpretation and liberal application of the *res ipsa* rule provide a precedent of landmark significance for future malpractice litigation.

In *Weiss v. Axler* the plaintiff sought damages for loss of her hair following a permanent wave treatment in the defendant's beauty salon. Her complaint contained a general allegation of negligence, and in addition averred specific negligence of the beauty operator either in using too strong a wave solution or in allowing the solution to remain in the hair too long. As evidence of the specific negligent acts, the plaintiff testified that the defendant had orally stated his opinion that the damage had resulted from either too strong a solution or too long an exposure.

The defendant denied any negligence and denied making the claimed admission against interest.

Over objection the trial court instructed the jury on the law governing *res ipsa loquitur*. The jury found for the plaintiff. On writ of error, the defendant contended that the case was not a proper one for application of *res ipsa loquitur*, especially in view of the fact that the plaintiff had introduced evidence of specific acts of negligence and therefore there was no need to infer negligence occurring in some unknown manner.

The court, in a scholarly opinion by Mr. Justice Frantz, reviewed the hopelessly confusing and contradictory prior Colorado case law on *res ipsa*, then seized the opportunity presented to clear these muddy waters. Unanimously the court *held*: (a) the case was a proper one for application of the *res ipsa loquitur* doctrine, and (b) evidence of particular acts of negligence does not preclude reliance on *res ipsa*. Concerning the procedural effect of *res ipsa loquitur* the court declared: (1) whether the doctrine applies to the particular case is a question of *law* to be determined by the trial judge upon the plaintiff's evidence, (2) once the trial judge determines that the doctrine applies, there arises a "compulsive presumption of negligence" which is a presumption of *law*, not

fact, and (3) this presumption shifts the burden of *proof* (not merely the burden of going forward with evidence) and is "conclusive as a matter of law" unless the defendant satisfies the jury "by a preponderance of the evidence that he was not negligent."

"Thus," said the court, "the sole question in a *res ipsa loquitur* case is: has the defendant *overcome* the prima facie case of negligence against him by establishing by evidence satisfactory to the jury that he was not negligent?" The presumption is not necessarily destroyed by a mere explanation from the defendant showing how the injury occurred or that he was not negligent. It is for the jury to decide not only whether the defendant's explanation is sufficiently convincing to justify exonerating him, but also whether the defendant's witnesses are worthy of belief.

Although the opinion left several questions unanswered, it certainly represents great progress in a murky area of the law. More important, perhaps, it indicates that the present Supreme Court believes that a trial should be an effective search for truth and that where the very nature of an occurrence indicates that someone must have been careless, the party having best access to the true facts must bear the onus of producing them or suffer the consequences.

Does the *Weiss v. Axler* rationale apply to medical malpractice cases? A 1912 Colorado Court of Appeals dictum indicated that the fact that a fractured bone healed in imperfect position could not be treated as evidence of negligence, and the doctrine of *res ipsa loquitur* could not be applied. But this seems to be no more than a proper application of the well settled rule that mere proof of an unfortunate result is not evidence of negligence.

Medical malpractice cases should be treated the same as other kinds of negligence cases for purposes of determining whether *res ipsa loquitur* applies. Professional men should be entitled to the same legal protections afforded others, and the usual prerequisites for application of *res ipsa* should apply.

It is doubtful whether *res ipsa loquitur* could ever apply to a case where the claimed negligence is that the defendant employed a procedure not medically approved for the ailment being treated. Since the only recognized standard of care in such cases depends upon contemporaneous expert opinions from other doctors practicing in localities similar to that where the alleged negligence occurred, it would seem to follow that the plaintiff's burden to prove the standard could not be discharged by *res ipsa loquitur*. Here the case would fail to meet the usual condition limiting the doctrine to cases where the occurrence is "of a kind which ordinarily does not occur in the absence of someone's negligence . . . ."

However, where the negligence charged is the careless performance of a medically approved procedure, there would seem to be no objection to applying *res ipsa loquitur* if the usual conditions are met. For example, what if *Weiss v. Axler* had involved not chemical injuries incurred during a hair wave treatment administered by a beauty operator, but similar injuries received during a scalp treatment administered by a dermatologist? Should the court have applied a different rule of law?

Some might insist that the 1952 case of *St. Luke's Hospital Association v. Long* stands in the way of applying *res ipsa loquitur* to medical negligence. There a three-year-old child, in the hospital for removal of his tonsils and adenoids, was strangled when he slipped, while asleep, through the side rails of a hospital bed and caught his head between them. Although the plaintiffs' evidence did not show exactly how the unfortunate incident happened, the defendant, by affirmative evidence, "explained and made known the cause of the death and disclosed all its knowledge and means of information as to the accident." The court indicated that on the plaintiff's evidence alone *res ipsa loquitur* would have properly applied, but held that the defendant's full disclosure gave the plaintiffs "equal knowledge and means of information and the *res ipsa* doctrine could no longer be invoked." It seems clear that on this point, i.e., that the defendant's explanation may deprive the plaintiff's *res ipsa loquitur* case of its character as such a case, *Weiss v. Axler* has overruled the *Long* case.

In other jurisdictions there is a fast growing body of authority applying *res ipsa loqui-*

tur to medical malpractice cases. It may or may not be significant that one leading California malpractice case applying *res ipsa* was quoted with approval in *Weiss v. Axler* and cited with apparent approval in a 1957 Colorado malpractice case which was tried on a *res ipsa* theory. There is no reason to expect that *res ipsa loquitur* will not be applied in future Colorado malpractice cases.

BURDEN OF PROVING CAUSATION

One final point on the plaintiff's burden of proof deserves thorough discussion in a separate article and therefore will receive but brief mention here. This is the claimant's obligation to prove that the defendant's negligent act caused the injuries. Many a plaintiff's bark has sailed serenely past the straits of negligence only to be wrecked on the rocky coast of causation.

Proof of causation has a dual aspect. As usual in negligence cases the legal test of proximate cause must be met. Nearly always in malpractice cases the additional hurdle of medical cause is present. True, in an occasional case nothing but an identifiable doctor's negligence could account for the injury, as in some "sponge" cases. In a rare case, too, the mere proximity in time between the physician's ministrations and appearance of the patient's injury symptoms may be sufficient. For example, where an osteopath suddenly and with great force twisted the plaintiff's neck, and the plaintiff instantaneously experienced nausea, terrific pain and paralysis, the Supreme Court felt that causation had been sufficiently shown to take the case to the jury.

In most malpractice cases, however, proof of causation requires medical testimony. Thus where the question was whether a particular trauma caused an eye infection which did not develop until several months later, medical testimony that the infection *possibly* could have resulted from the trauma was held insufficient to support a jury verdict. In malpractice cases, as in other personal injury cases, evidence that the cause-effect relationship is a possibility is not sufficient; opinion evidence must indicate at least a probability.

Once the plaintiff by competent evidence has established that the defendant's act *probably* was the efficient cause of the injuries, it would seem that the defendant would have the burden of going forward with contrary evidence or with evidence of some other cause independent of his own act. But there is some Colorado authority indicating that the plaintiff's affirmative showing that the defendant probably caused the injury must be accompanied by evidence "eliminating the intervention of other causes which might exist."

After the burden of proving negligence, causation and damages has been met, the plaintiff will have to meet and overcome whatever defenses the defendant has raised.

Defenses

The usual defenses to negligence liability are available in medical malpractice cases on the same terms as in other cases. For example, the plaintiff may be guilty of contributory negligence in failing to follow his physician's advice to remain in the hospital for further treatment or diagnosis or failing to seek other medical care after becoming dissatisfied with the defendant physician's ministrations.

For the most part the law governing defenses presents few problems peculiar to malpractice law. One possible exception is the defense of mistake of judgment, which has already been discussed. Two others are the defenses of release and statute of limitations.

RELEASE

The nature and theory of the plaintiff's claim may be important in determining whether the defense of release is available to the defendant. This defense is the plea that the plaintiff has released another and the release operates to bar the malpractice claim. For example, in *Sams v. Curfman* the plaintiff was injured when his car collided with a creamery company truck. The injuries he thus received were treated by the defendant physicians. First the plaintiff sued the creamery company and its driver, receiving a sizable cash settlement in return for signing a release in the usual broad terms. The physicians were not parties to the action thus compromised and they were not mentioned in the release.

Soon after settling the first lawsuit, the

plaintiff filed a second, entirely separate, action against the physicians. This suit asked compensatory and exemplary damages for "gross negligence and wrongdoing" in diagnosis and treatment of the same injuries involved in the first action.

The doctor-defendants pleaded in bar the settlement and release with the creamery company, and the trial judge granted the defendants judgment on the pleadings. In the Supreme Court, the plaintiff argued that his complaint for malpractice alleged both a tort and a breach of contract. He contended that the contract action against the physicians should not be barred by his settlement of a tort action against the creamery company. Moreover, he asserted, there was no causal connection between the wrong of the creamery company driver and the later malpractice.

Defendants countered that the action against the doctors was in form and nature a tort action, that it asked damages which would have been recoverable in the initial action as proximately caused by the creamery's original wrong, and that the one cause of action for those damages had been settled and co-liable tortfeasors released.

The high court, after a brief struggle with the issue whether the complaint sounded in tort or contract, held that the complaint set out a tort cause of action, and therefore it was barred by the release. By implication, at least, the opinion indicates that an action against the physicians for breach of contract would not have been barred by settling the claim against the prior tortfeasor.

The *Sams* case points out a pitfall for plaintiff's attorneys. They should not be tempted, in cases involving medical malpractice in treating injuries caused by a prior tortfeasor, to settle with the wrongdoer whose tort brought the claimant to the doctor's office, even where the original tort caused minor damage in comparison with the malpractice, or where the original tortfeasor's liability is highly doubtful. Even assuming such a settlement would not bar a later contract claim against the physician, damages for breach of contract might be severely limited, and of course no exemplary damages are available in a contract action.

It might be noted that, strictly speaking, the *Sams* rationale may not apply today. The court carefully specified that the complaint was governed by rules of pleading which did not allow commingling of tort and contract theories in a single cause of action. It is possible that under the present more liberal pleading the court would hold in similar circumstances that if the facts alleged stated a claim on a contract theory, settlement of a tort claim against a prior wrongdoer would not bar the contract action against the doctors. Moreover, the whole idea that a release of one joint, concurrent or consecutive tortfeasor releases all others has justification in neither logic nor legal history and has been severely criticized. This is another area where the Supreme Court of Colorado, which of late has so dramatically demonstrated its determination not to adhere blindly to unsound or unjust precedents, may greatly improve the law if given the opportunity.

The Colorado court has already recognized certain limitations on the harsh rule that the release of a prior tortfeasor releases a physician who negligently treats injuries caused by that tortfeasor. Thus where the initial injury is covered by workmen's compensation, the injured workman may, in some cases, accept his compensation award and release his employer without necessarily sacrificing his action for medical malpractice. Whether this is possible in a particular case turns on the theory of the action and the relation of the party sued to the plaintiff.

For example, in *Hennig v. Crested Butte Co.* the injured workman, after accepting a compensation award and releasing his employer, brought action against the *employer* for injuries allegedly sustained through malpractice of a physician who had been employed by the defendant-employer to treat the workman. Apparently the plaintiff sought to hold the defendant, the employer of *both* the physician and the plaintiff, vicariously liable for the physician's alleged malpractice. This, said the Supreme Court, could not be done in the face of a release of the same defendant after payment of a compensation claim filed for the same injury and all disability arising from or connected with it.

It should be noted that the *Hennig* case said nothing about the right of an already compensated workman to sue the *doctor*

whose negligent treatment may have greatly aggravated the injury incurred on the job. *Hennig* was an action against the *employer*. There are many reasons for allowing a separate medical malpractice action after settlement of the original workmen's compensation claim. First, the compensation act was intended as humanitarian, beneficial protection for injured workmen, not as a refuge for negligent doctors. The latter are strangers to the act, and, unlike covered employers, have not exchanged the disadvantage of liability without fault for the advantage of liability limited in amount. The act's purpose of benefiting workmen should not be perverted into denying them a common law action probably included in the Bill of Rights guarantee of a remedy for every wrong.

Second, the amount of a workmen's compensation award has little or no relation to the actual pecuniary loss of the claimant. Such an arbitrary and often pitifully inadequate award should not be substituted for an opportunity to obtain satisfaction in the form of damages commensurate with the injury. There has already been too much judicial confusion of "satisfaction" of claims with "release" or tortfeasors. Legislative deprivation of this claim for compensatory damages might well constitute a taking of property without due process.

Third, the claim against the employer is essentially separate and different from the malpractice claim. The job-incurred injury is generally separated in time, place and causation from the malpractice injury. The employer and the doctor usually are not joint nor even concurrent tortfeasors. The employer's liability is not based on fault but is relational, arising out of the contract relation of employer and employee. The physician's liability, on the other hand, is nearly always in tort. Often the damages may be divisible or at least capable of apportionment. For example, an employee may incur a hernia from on-the-job strain. If, in preparing him for a hernia operation, the surgeon negligently allowed him to fall off the operating table and fracture an arm, there would be no problem whatever in allocating damages to the separate injuries. Yet even in this kind of case it is not clear that the workman would have a separate claim against the surgeon if the surgeon had been employed by the workman's employer.

Fortunately it appears settled in Colorado that the injured employee has a separate claim for malpractice against a physician whom the employee himself selects and pays to treat an injury covered by workmen's compensation. Therefore a settlement of the workmen's compensation claim in such a case does not bar a later action against the workman's personal physician for malpractice. It is submitted that the rule should be the same when the physician is selected and paid by the employer or his compensation insurance carrier. Mere formalities, such as who retained and paid the physician, do not affect the inherent separateness of the claims, and they should not determine whether settlement of one bars the other.

STATUTE OF LIMITATIONS

The statute of limitations as a defense presents special problems in malpractice cases. At least two of these problems have been dealt with by the Colorado Supreme Court and are worthy of discussion here. They are the problems encountered by courts when asked to decide: (a) when the statute of limitations begins running or is tolled, and (b) which of several possibly applicable statutes of limitations properly applies in a particular case.

A third problem, the question whether the special two-year Colorado malpractice statute is constitutional, has never been raised for decision by the Supreme Court. However, the question has more than academic interest and will be discussed briefly here.

When statute begins running — tolling. The weight of authority holds that a statute of limitations governing malpractice begins to run when the act or omission alleged as malpractice occurs. The majority seem to enforce this view even where the malpractice is not discovered until after the statute has barred any action. Other courts, however, have held that the statute does not commence running until the malpractice results in injury. The latter view seems more consistent with the broader rule that statutes of limitations do not start running until a claim accrues, at least when it is considered that

actual loss or damage is an indispensable element of a negligence claim. Still another minority view holds that the statute does not run prior to the time the plaintiff discovers or by reasonable diligence should have discovered the malpractice.

The Colorado Supreme Court has never directly declared which of the above views it prefers, and on at least one occasion has expressly declined to decide when the statute commences to run, while seeming to hold, in effect, that the statute does not run until discovery of the injury.

Two Colorado cases have involved the problem of tolling the statute of limitations. The first, and most dramatic, was *Rosane v. Senger*. There the defendants had left a gauze pad in the plaintiff's abdomen during surgery performed on her in 1930. After more than ten years of suffering without realizing the cause, the plaintiff learned through exploratory surgery performed by another doctor that the gauze pad left behind in the prior surgery had been causing her discomfort. Thus it appeared from the plaintiff's own evidence not only that injury, i.e. damage, had occurred, but also that she had discovered the *fact* of injury (although not the precise cause) more than two years before she brought suit. She instituted action in 1941, over 11 years after the *act* alleged as malpractice, but only about one year after she first learned of that act. The Supreme Court opinion does not state whether the defendant surgeons knew they had left the pad inside the plaintiff, nor is there a recital of any specific attempt by them to conceal their mistake.

As seen by the court the issue was: "Does justifiable delay, due to plaintiff's ignorance of the *cause* of a *known injury,* stop the running of the statute when plaintiff has used every reasonable effort to ascertain that cause and been frustrated solely by defendants' *concealment?* In other words under such circumstances, when did the cause of action accrue?"

The Supreme Court, acknowledging but repudiating the contrary majority view, held that the statute commenced running only upon the plaintiff's discovery that the pad had been left inside her. In reference to the prevailing rule that the statute is tolled only by *fraudulent* concealment, the opinion declared: "We are not impressed with the reasoning which supports the materiality of fraud." The court reasoned that whether the concealment was fraudulent or not made no practical difference to the plaintiff, for without knowledge of facts upon which to base a complaint, "the victim (would be) equally helpless regardless of the motive for concealment." Further the court expressed concern that strict enforcement of the majority position might raise serious constitutional questions.

Clearly the *Rosane* case establishes that to toll the statute no fraud in the sense of scienter or actual intent to deceive need be shown. But throughout the opinion the court indicates that *concealment* is the effective ingredient. Yet nowhere is there mention of what constituted concealment in this case. It is not even stated that the defendants *knew* they had left the pad inside the plaintiff. This poses the question whether the court really *held* that mere ignorance of facts constituting the claim tolls the statute. If this be the proper interpretation, the case created a new and not generally recognized exception to the general rule that the plaintiff's mere ignorance of facts giving him an action does not delay the running of the statute of limitations. The latter rule has been recognized in Colorado, but in a case rejected in *Rosane* as not in point and later modified if not overruled by legislation.

Colorado's apparent adherence to the liberal minority view that ignorance of the facts constituting a cause of action tolls the statute was affirmed if not extended in the 1957 case of *Davis v. Bonebrake*. There the plaintiff alleged that during a hysterectomy done August 17, 1951, the defendant surgeons left a sponge in her abdomen. A second operation was performed September 5, 1951, and the plaintiff learned in October, 1953, that the latter operation had been done for the purpose of removing the sponge left behind in the first operation. The complaint was filed October 16, 1953, more than two years after both operations, but shortly after the plaintiff obtained specific knowledge of the alleged malpractice.

The plaintiff contended that the defendants had been guilty of fraudulent conceal-

ment which tolled the statute. The defendants cited testimony of the plaintiff as showing that she knew, or with reasonable care should have known, shortly after the first operation that something had been left inside her. Specifically, the plaintiff had testified in a deposition that shortly after the first operation she noticed on her abdomen a lump about the size of a partially opened fist. The following cross-examination occurred:

"Q. Now, you thought that it was a foreign object of some kind, didn't you, Mrs. Bonebrake? A. Well, I didn't think you could grow something just that fast . . .

"Q. But you believe (sic) that it was not something that was part of you, is that correct? A. Well, I felt — I mean — there was something there."

Plaintiff further testified that she knew something was wrong but had no idea precisely what the matter was. In addition she claimed that she had questioned the doctors and the surgical nurse seeking information but had been rebuffed. Eventually she had learned from the surgical nurse that the second operation had been performed to correct the error of the first.

On appeal of a trial court judgment for the plaintiff, the Supreme Court held that the evidence presented a jury issue whether the plaintiff knew about the malpractice more than two years before she filed action. An additional ground for affirming the trial court on this point, said the high court, was that, at best, the plaintiff's testimony as to what occurred during the allegedly negligent operation "cannot arise above that of the conjecture of a non-observer of the event." The court indicated that such testimony is incompetent to establish "discovery" by the plaintiff which would start the statute of limitations running.

Bonebrake indicates the lengths to which the Supreme Court will go to avoid enforcing the two-year statute of limitations. Mr. Justice Day, in a dissenting opinion, asserted that the majority opinion in effect had repealed the statute. This general attitude of the court toward the special malpractice statute of limitations is extremely significant in a context yet to be discussed, the question whether the special statute is unconstitutional.

Which statute of limitations applies. The leading Colorado case governing applicability of limitations is the *Smith* case. There the complaint alleged that the plaintiff had employed the defendant surgeon to perform a circumcision operation, but the defendant, "without Plaintiff's authorization did then and there commit an unlawful battery . . . by performing upon Plaintiff's person a surgical operation known as a Vasectomy which rendered the Plaintiff sterile. . . ." No circumcision was performed. It was not claimed that the vasectomy was performed in any but the most careful and expert manner; the sole complaint was that the claimant did not get the operation he asked for.

Alert defense counsel moved to dismiss on the ground that the action, by the plaintiff's own characterization, constituted a suit for "an unlawful battery" and since it had not been commenced within one year after the defendant's act, it was barred by the one year statute of limitations governing battery cases. The trial court denied the motion, holding the special two-year malpractice statute of limitations applicable. After taking evidence, the trial judge directed a verdict for the plaintiff on the issue of liability, leaving only the question of damages to the jury.

On writ of error, the Supreme Court of Colorado upheld the trial court decision that the special two-year medical malpractice statute of limitations applied. The high court, however, acknowledged that negligence in treatment and treatment without employment present claims basically different in nature. "The one is based on the existence of a contract and authority for service, and the other upon the lack of such contract or authority. The one is based on lack of care or skill in the performance of services contracted for, and the other on wrongful trespass on the person regardless of the skill or care employed." Distinguishing a prior case where the complaint had alleged battery in continuing treatment after the patient's consent had been revoked by discharging the physician, the Supreme Court ruled that the special two-year statute governing malpractice applies wherever the doctor's act occurs while there is in force a contract of employment from which a professional relation to the patient arises. The court reasoned that the

gist of the action was an alleged negligent act, not in lack of surgical skill but in failure to observe "that degree of care which, as practitioners, they owed to their patient in the practice of their profession."

The opinion indicated that wherever the basic relationship of physician and patient is established, malpractice is not classifiable, for purposes of statutes of limitations, as either battery or negligence, but is a kind of hybrid. Said the court, "While an unauthorized operation is, in contemplation of law, an assault and battery, it also amounts to malpractice, *even though negligence is not charged.*"

Thus it appears settled in Colorado that the special two-year medical malpractice statute of limitations applies to either negligent or intentional acts of a doctor who has been employed to perform *some* treatment or operation. But this by no means solves all the problems.

Although the special two-year malpractice statute of limitations applies even to claims founded on treatments or operations *beyond* the patient's consent, it probably does not apply to actions arising from treatment or surgery *without* consent. A dictum in the 1954 *Smith* case declared that if the patient consents "to no operation at all, then clearly it is a case of assault and battery, which would be barred by the (one-year) statute of limitations."

The *Smith* opinion carefully distinguished the facts there presented from the facts alleged in the earlier case of *Cady v. Fraser*. In *Cady* the plaintiff claimed "malpractice similar to an assault" consisting of the physician's continuing treatment after the plaintiff had told him to "get off the case. . . ." Although the precedent value of *Cady* is weakened by the fact that there the plaintiff's claim died for lack of proof, the significance of the case lies in the fact that in *Smith* the Supreme Court took pains to distinguish the facts *alleged* in *Cady*. Thus the *Smith* opinion clearly implied that facts such as those pleaded in *Cady* would present a claim in the nature of assault and battery, subject to a one-year statute of limitations. This rationale affirms the fundamental proposition that the physician-patient relation is consensual and indicates that the relationship may be terminated by the patient's withdrawing a consent previously given. Treatment after withdrawal of consent would amount to trespass. *A fortiori* it would seem that a physician who renders treatment without ever obtaining consent in the first instance commits battery and, if the patient is conscious, both assault and battery. An action seeking damages for such conduct would have to be brought within one year. Under the *Smith* rationale it would seem proper to infer that a malpractice claim based on a breach of contract theory would be governed by the two-year malpractice limitation rather than the statute of limitations governing other contract actions.

Constitutionality of the special statute of limitations on malpractice. The *Smith* precedent, obviating many problems inevitably present where the inherent unlikeness of various kinds of malpractice claims is recognized, rests on the bald assumption that the special two-year statute of limitations is constitutional. If that statute is not constitutional, a question never decided by the Colorado Supreme Court, then, presumably, a malpractice claim would be barred in one year or six years depending on whether it was in the nature of battery, negligence, or breach of contract. Thus a consideration of the constitutionality of the special two-year medical malpractice statute becomes imperative.

The Colorado Constitution guarantees that, "Courts of justice shall be open to every person, and a speedy remedy afforded for every injury to person . . . and right and justice should be administered without sale, denial or delay." In a 1934 case the Supreme Court indicated that this provision might be offended by legislation abrogating the common law rule that, "a physician or surgeon is beholden for injury to his patient resulting from malpractice." The court there implied that an attempt by the legislature to substitute a workmen's compensation claim for an injured employee's malpractice action against his physician would be unconstitutional.

In a 1944 case involving the special medical malpractice statute, the court served notice that, "A legal right to damage for injury is property and one cannot be deprived of

his property without due process." More recent opinions indicate that the present Supreme Court, to the credit of its incumbents, will not meekly tolerate legislative denials of or infringements upon constitutional rights.

But the Colorado Constitution poses a more potent threat to the special malpractice statute of limitations. The Constitution expressly forbids the general assembly to pass "special laws . . . for limitation of civil actions. . . ." Prior to 1925, there was no special statute of limitations on malpractice in Colorado. Presumably members of the healing professions were then shielded only by the same limitations statutes applied to others, including other professional men liable to malpractice claims. But by the 1920's the American Medical Association was making its influence felt in legislatures across the land. In 1925 the Colorado legislature passed the present special statute. With magnanimous generosity, or perhaps with one eye on the constitutional prohibition of class legislation and the other on the electorate, the statute's protection was extended to not only the more orthodox practitioners of medicine and surgery, but, in addition, to anyone licensed to practice, "chiropractic, osteopathy, chiropody, midwifery, or dentistry. . . ." This broad coverage may somewhat bolster the statute against a contention that it is class legislation.

Notably, however, the statute does not protect a nurse or hospital from an action for the same *kind* of negligence, possibly the same *act* of negligence, for which an action against the named practitioners would be barred. This points up the essential weakness of the statute. It is not in essence a legislative declaration that a certain *type* of action—malpractice—is a disfavored action and will be barred unless promptly instituted. It is not like the statute barring actions for assault and battery, false imprisonment, or slander and libel after one year. Those actions are barred whether the defendant be a doctor, lawyer or Indian chief. There the basis for legislative classification is the nature of the action, not the profession of the defendant. But the malpractice statute is solely for the benefit of a favored class of medical practitioners, and bars *all* actions whether based on "tort or implied contract." What non-arbitrary and non-discriminatory reason exists for classifying all "tort or implied contract" malpractice actions against a doctor differently from the same *kinds* of actions against a nurse or a lawyer? The arbitrariness of the classification would be immediately apparent to physicians if the legislature should provide that all negligence actions be barred in *two years*, except that negligence actions against a practitioner of "medicine, chiropractic, osteopathy, chiropody, midwifery or dentistry . . ." should not be barred in less than *ten years*. That the Colorado Supreme Court is not thoroughly in sympathy with the special statute is indicated by recent decisions severely limiting its scope. Given an opportunity, the court might seriously consider invalidating the statute altogether.

Conclusion

As should be obvious from the above discussion, the medical malpractice area is one of great technical and practical difficulty for the lawyer. For the doctor the increasing frequency of malpractice claims presents a growing threat to professional reputation as well as financial solvency. Physicians should not be distracted from concentrating their best efforts on behalf of a patient by the ever-present storm cloud of potential legal liability. This is an area calling for greater cooperation of the medical and legal professions in the public interest. The public interest would be served by more stringent enforcement of the lawyer's duty not to accept claims not well founded in fact, law and basic justice. A professional man's most valuable asset is his reputation for competence in his chosen field. An attorney as a professional man should refuse to have any part in damaging the reputation of another professional man unless convinced that the claimant has really been injured and that his claim has genuine and provable merit.

The Colorado Medical Society and the Colorado Bar Association are presently working to establish a joint medical-legal board to hear and screen malpractice cases. If a claim is found to have merit, the medical society will aid the claimant in obtaining needed expert evidence. If a claim is found

to be without merit, the claimant will be left to his usual legal remedies. It is the hope of both cooperating groups that this screening process will be effective in helping claimants' attorneys determine for themselves whether claims they are pressing should be litigated. If the plan functions properly, it should eliminate many groundless claims not only short of actual trial, but prior to release of publicity which may cause irreparable damage to an entirely innocent doctor. This is an effort at interprofessional cooperation which should have the sincere support of every man of good will in either profession. •

The present status of steroids*

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Here is a quick review of the confusing array of cortisone derivatives with which we are confronted today. Trade names and manufacturers are included, making this a handy reference.

IN THE DECADE WHICH HAS PASSED since the development of Cortisone in 1949, tremendous amounts of effort, time, and money have been expended in the search for new, improved therapeutic agents of steroid structure. Interesting developments in this period of time have been the discovery that the original glucocorticoid activity of Cortisone can be increased many times, and conversely, that the accompanying catabolic and mineral retention effects are able to be separated in new, selectively acting compounds. In this paper it is desired to review the chief advances that have been made in the development of steroids of glucocorticoid activity, those with anabolic and mineral excretion effects, and to make a few brief remarks about some other therapeutic indications for steroids in entirely different areas.

*Presented to the Montana Medical Association, Interim Session, April 3, 1959, Helena, Montana. Twenty figures, showing structural formulae, beneficial effects, and disadvantages have been omitted because of space limitations.

Development of steroids

Among the most useful steroids employed up to now are diosgenin and hecogenin from Mexican plants; cholesterol and stigmasterol, chiefly from beef nervous tissue or from fish oils and soy beans; and cholic acid or desoxycholic acid from bile salts. The latter were used originally and still are employed in the manufacture of Cortisone.

It is also interesting to note that in spite of advances in the steroid field, few of the original products are no longer being used. This is explained by the fact that many of the earlier steroid drugs are now employed as starting materials or as intermediates in the manufacture of the new products. We might say that old steroids never die, they just turn up under a new label with slight structure modifications.

A large number of pharmaceutical firms have entered the picture in the development of steroid products and physicians are being constantly assailed with literature from these companies. Chief among the leaders in new developments to date are Merck, Upjohn, Searle, Pfizer, Schering and Syntex of Mexico. Foreign companies are joining the parade and undoubtedly some of their products will appear in our armamentarium in the near future.

Therapeutic effects and side effects

The emphasis during the original hunt

for steroids was placed on anti-inflammatory activity. Cortisone was the first successful drug of this type and was soon followed by Hydrocortisone, which had increased glucocorticoid effects as a result of the alteration of the ketone at C_{11} to a hydroxyl. Nitrogen loss, mineral retention, digestive upset and other side effects remained serious problems with Hydrocortisone in spite of its greater potency as an anti-inflammatory agent.

This led to further investigation and the next to appear was the 9-alpha-fluoro hydrocortisone (F-Cortef) in which the anti-inflammatory activity was stepped up by a factor of from 10 to 15 times that of hydrocortisone. At approximately the same time (1954) that the 9-alpha-fluoro compounds came out, Schering produced the "Pred" steroids in which an additional double bond in the 1-2 positions enhanced the anti-inflammatory activity from three to five times with decreased salt retention being observed. Prednisone, Prednisolone, 6-methyl prednisolone, Upjohn-Medrol, 1956, and Triamcinolone produced by Lederle in 1956 as Aristocort or Kenacort, as well as Dexamethasone, called Decadron and Deronil by Merck, Sharpe and Dohme in 1958, are representative of the variety of products which gained acceptance on the market in a space of only four years.

All of the above show increasing anti-inflammatory activity but with varying degrees of effect on mineral retention or excretion. Each compound has certain proposed advantages, and less often mentioned, certain disadvantages. The increase in potency of some has made therapeutic use difficult and a few seem to lend themselves more specifically to topical use rather than to general systemic dosage.

The addition of the methyl group in 6-methyl prednisolone, and subsequently the introduction of a fluorine atom, and the conversion of the 21 hydroxyl group to a 21 desoxy group, has resulted in still greater glucocorticoid activity. Another development was the addition of an additional fluorine or chlorine atom for further increased effect. Oxylone from the Upjohn Company is an example of the last named type. It is claimed to have 40 times the anti-inflammatory activity of hydrocortisone when applied topically but is only equal to hydrocortisone when used orally. This 40:1 ratio of topical over oral activity should result in few systemic effects from the use of the compound locally.

Progestational and estrogenic hormones

Advances have been made in certain progestational and estrogenic compounds as a result of these new developments in steroid chemistry. Removal of the CH_3^- results in an increased biologic activity when this new compound is administered. Further alteration of the structure has resulted in Norlutin (Parke Davis and Company) which was originally prepared by the Syntex Company in Mexico, a modified Norlutin, with the C-17 hydroxy esterified for still greater activity, Enovid (Searle) which is an isomer of Norlutin. Further modification of this basic molecule has yielded more compounds with increased potency but which generally require priming with estrogens in clinical conditions.

Estrogens of the Equilin type, formerly obtained only from urine in very small yields, the first such extraction being in the order of a few mg. from over 55,000 liters of pregnant mare's urine, have now been halogenated at the 16 position for modified effects. One important observation has been that this latter type of compound is useful in mobilizing cholesterol with little demonstrable estrogenic activity. The use of both Norlutin and Enovid as antifertility agents is increasing and it is certain that a great deal of study will be directed to the evaluation of compounds of this class in this country, as is now being done in Japan and other populated areas of the world.

Androgens

Considerable emphasis has been also directed to the development of steroids with androgenic activity. Starting with testosterone Searle has prepared Nilevar which has the generic name of 17-ethyl-19 nortestosterone. Nor-compounds are being studied with great interest as they have been found to lose much of the androgen activity but to have greatly increased anabolic properties. Another superandrogen is fluoxymestrone, marketed by Upjohn as Halotestin, by Squibb as Oratestril, and by Ciba as Ultraden. The

use of these substances in building muscle tissue in premature infants and in debilitated persons promises some interesting developments in the future. Additional research is being directed to the development of agents with steroid structure for the treatment of cancer, but no important breakthrough has been reported as yet. Activity is also continuing among steroid chemists in the fields of cardiovascular diseases, hypertension, hemostatics, anesthetics, antibiotics and cosmetics.

Future prospects in steroids

A number of rather surprising effects of some of the newer steroids have led the researchers off on tangents. Two compounds of interest have come from the laboratories of Syntex and Schering. Not only have they shown high anti-inflammatory activity but also they demonstrate a reversal of the previously observed side effect of salt retention. In other words, these compounds show considerable possibility as diuretics as they actually enhance sodium excretion. Thus, further study may result in the production of compounds which would be classed as diuretic steroids without any appreciable anti-inflammatory effect.

The use of newer compounds with androgenic activity in the treatment of breast cancer is being tested by the National Cancer Services Center Breast Cancer Group. Among these androgens are 4-chlorotestosterone, and 2-hydroxymethylene, 17-methyl dihydrotestosterone, which is orally effective. The latter drugs have increased anabolic activity with reduced androgenic effects. Veterinarians are becoming interested in the potential of new progestational compounds. Mention of the widespread testing of these products as antifertility agents in human beings has been made previously.

Other outlooks for new steroids include use of insecticides as potential tranquilizers and as food additives in developing better meat animals. It is difficult to predict the results of the ramifications of research in the field of steroid chemistry but hardly an area of therapy has escaped notice in these studies. Little is being said publicly by researchers for obvious economic reasons but we shall undoubtedly see many interesting new developments in the near future.

Economy of steroid production

Two charts which appeared in the Chemical Week, January 31, 1959, show something of the importance of steroids in the total picture of drug sales and development costs. They show the portion of the more than $2,252 million in sales of drugs which have resulted from the marketing of steroids in 1958, and indicate the growth in sales in the seven years just past.

Development of these products calls for large research budgets; for example, Schering has earmarked over 30 per cent of its $7.5 million 1959 research budget for hunting new active steroids. More emphasis is placed here and more people are engaged in this area of research than in any other segment of the pharmaceutical industry. Due to the great complexity of the steroid molecule and the high cost of research, little actual development other than in pure synthesis is being done in educational institutions in this field of chemistry.

The role that the practitioner of medicine plays in the total picture is of great importance and he is not to be envied for the difficult choices that he will have to make in administering these drugs and in the evaluation of their effects.

Also tabulated are the relations between the more important steroids as far as potency and effect are concerned. The more concentrated the drug, the more care that must be exercised in its use and the smaller is the margin for error. It is sufficient to say that greater skill will have to be employed to correctly diagnose and prescribe these more potent drugs than has been ever required before. •

Cancer of the prostate*

Louis M. Orr, M.D., Orlando, Florida

Incidence of prostatic cancer is amazingly high after the age of 50. Many of us are more personally concerned than we realize! Here is increased insight into this dominant problem.

CANCER OF THE PROSTATE is one of the conditions in which I hope the interest of the medical profession has increased as the proportion of aged persons in the population has risen. In addition to the relative increase in incidence owing to the large number of persons in the age group most subject to this form of cancer, there has been an actual increase in incidence resulting from better detection and earlier diagnosis. Consequently, even though the survival rate has been favorable, influenced by the effort at early diagnosis, much still needs to be done to encourage wider use of the most effective means of diagnosis and treatment that have so far been developed.

Although there is no question that cancer of the prostate is a common condition in aging men, the precise incidence is not known. It has been variously reported as ranging from 14 to about 50 per cent on postmortem examination in men over the age of 50. Some pathologists have claimed that it is the commonest malignancy in this age group, while others give it second place to cancer of the skin or even third place behind cancer of the stomach. Whatever the exact figure, there is no doubt that, even more than other cancers, cancer of the prostate will continue to rise in incidence as the population grows older.

Granted that the high rates of occurrence referred to are based on autopsy findings rather than clinical experience, there is a marked discrepancy between the death rate from prostatic cancer and the incidence of this type of cancer. After all, in many cases in which microscopic cancer was found at autopsy, the patient had died of other causes and was unaware of his prostatic malignancy. One reason is, of course, that prostatic cancer usually develops slowly and probably often is present in situ years before it develops into a clinically recognizable condition. Exactly what stimulates the growth and dissemination of the malignant cells is not understood, but apparently it is a factor related to the decline in androgen secretion. Like bronchogenic cancer, early prostatic cancer is simply not evident to the patient or to the physician on casual examination. It is not difficult to diagnose but lack of suspicion of the presence of the malignancy prevents its discovery at a stage in which its complete removal is possible.

At any rate, owing to earlier diagnosis resulting from the medical profession's appreciation of these facts and to more efficient treatment, the death rate has not been commensurate with the increase in incidence. There have been several reports in which a significant proportion of men treated have survived as long as their counterparts of the same age in the remainder of the population had been expected to. In at least one series, reported by Jewett[1] several years ago, the 10-year survival rate was 49 per cent for patients whose prostatic cancers were confined to the gland at the time of surgery,

*Presented at the 13th Annual Rocky Mountain Cancer Conference, Denver, July 22-23, 1959. Dr. Orr was President, A.M.A., 1958-1959.

while the comparable survival rate for men of the same age in the general population was 53 per cent. These results are certainly dramatic enough to warrant special consideration of the means of early diagnosis and the possibilities for complete cure.

Early diagnosis and curative treatment

Short of accidental discovery at surgery, the only practicable means of early diagnosis is rectal palpation by the physician. In four out of five patients the carcinoma of the prostate develops first in the posterior lamella and becomes clinically evident as an elevated nodule or an isolated area of induration. Actually it should be said that only on routine rectal palpation is early diagnosis likely, for at a truly early stage there never is any urinary disturbance, discomfort or pain. In some few cases, the patient does present himself with complaints related to interference with urinary function related to prostatic hypertrophy that appears to be benign. The characteristic nodule is not present, and while the gland has lost its elasticity, it is uniformly soft. In a small proportion of such cases, through pathologic study of the resected prostate, malignant cells will be found. Total prostatectomy at this point is almost certain to prevent development of malignant disease traceable to the prostate. But such cases are relatively rare.

There is no better way to persuade the physician of the importance of routine rectal palpation than to recite the experience at Walter Reed Hospital[2], where half of the patients treated for prostatic malignancy from 1940 through 1952 were considered suitable candidates for radical prostatectomy. The five-year survival rate of those thus treated was over 50 per cent, twice that of those who could only be treated conservatively by other means. In other series that have been reported, only from 5 to 22 per cent of patients met the criteria for radical treatment, and even so, the higher figures come from clinics where many men are referred specifically for removal of a suspicious prostatic nodule. The explanation for spectacular results at Walter Reed is simple: The Army requires that all men over 40 undergo rectal examination annually and the routine palpation of the prostate multiplies the number of early prostatic cancers that are found in time for successful total removal.

In spite of the emphasis placed upon the prostatic nodule or induration as an indication of prostatic malignancy, it should never be taken for granted that such a nodule or area is cancerous. It may be due to a calculus, which x-ray examination will confirm and simultaneously reveal metastases if they are present. It may be due to infarction, leiomyomas, localized inflammation or tuberculosis, but only study of a biopsy specimen will differentiate these conditions from cancer.

The perineal technic of exposure of the prostate for either biopsy or resection is preferable in most cases to any other. It has the advantage of providing direct access to the entire posterior lamella as well as the best approach for complete extirpation of the prostate if the diagnosis of cancer is confirmed. The transurethral approach will often provide positive evidence of malignancy, but the lesion is more likely to be missed with this method because of the necessity of taking an extensive specimen which will include an adequate portion of the posterior capsule. Needle biopsy is used by many with success and has one advantage over the perineal approach in that impotence is never produced.

The perineal exposure of the prostate should not be made unless the surgeon is prepared to follow through with the radical removal of the entire gland upon obtaining a positive report from the pathologist. Obviously the other criteria for subjecting a patient to this operation should also be met, all of which support the thesis that the cancer is indeed confined to a single area that can be completely eradicated. On palpation there should be no evidence of invasion of the seminal vesicles, the bladder, or any area beyond the capsule. There must be no elevation of the buffered serum acid phosphatase or decline in the general physical condition compatible with extensive malignant disease.

Even if all these criteria are met, there is little point in performing an operation which can only be justified by the possibility

for cure if the patient's life expectancy is short, whether he has a prostatic cancer or not. The five-year survival rate of untreated prostatic cancer is not negligible owing to its slow growth, and one has to have a reasonable certainty that the radical approach will substantially prolong life. It is not felt that one can say dogmatically that no one over 70 is a suitable candidate for radical prostatectomy, though certainly it is the exceptionally vigorous man over that age whose cancer has been found in a very early state for whom it can be recommended.

The chief alternative to radical perineal prostatectomy, and a method which may be considered in suitable cases, is radical retropubic prostatectomy. When metastases of cancer to the local lymph nodes are encountered they are easily removed with this approach. As with perineal approach, the total removal of the gland, seminal vesicles and bladder neck intact and without damage to the external sphincter is possible.

Temporary, or occasionally permanent, incontinence is a possibility with either approach and the patient must be informed that impotence is an almost inevitable consequence of prostatic cancer, as surgery, hormonal treatment, or advancing disease itself suppresses normal powers.

Late diagnosis and conservative treatment

The diagnosis and treatment for prostatic cancer which has been outlined is applicable in regrettably few cases. Nevertheless, the outlook is far from hopeless for many of the patients whose cancers have obviously advanced beyond a curative stage even when they are discovered. The majority of all patients with cancer of the prostate are in this group, and although they will ultimately die of the malignancy there are several means of arresting the growth, relieving the discomfort and prolonging life. The patient must be made to understand that there are alternatives when one form of treatment has lost its effect.

In almost every instance where a patient complains of symptoms due to cancer of the prostate, the lesion has developed beyond the stage in which radical surgery is possible. Even in a large proportion of cases in which it is discovered before the patient is aware of a prostatic condition, it will have spread beyond the prostatic capsule, perhaps even with metastases. Many studies, with varying results, have been made to determine in which proportion of cases of prostatic disease malignancy is present. Enough evidence has been accumulated to reveal that about half the number of prostatic nodules are malignant and that in a smaller but still significant proportion of apparently benign cases of hypertrophy, cancer can be found. This justifies a thorough search for the disease in every case of obstructing prostatism.

It is a tragic commentary on our advanced standards of modern diagnosis that 51 per cent of the neoplasms diagnosed clinically or on gross examination on postmortem were found to have metastasized. Prostatic carcinomas of the lower grades of malignancy tended to remain localized longer than those of the higher grades. No relationship has been found between the size of the carcinoma and the incidence of metastasis or between carcinoma and associated atrophy, nodular hyperplasia, inflammation or calculi. Nor has any relationship been found between the number of interstitial cells in the testes and the carcinoma in the prostate.

Positive biopsy results are conclusive, but the clinical and laboratory findings usually leave little doubt when the prostate is found to be enlarged and hard, with an irregular nodular surface. Roentgenograms may reveal metastases, which in most instances extend to the spine and bones of the pelvis. Metastases to bone from prostatic cancer are seldom osteolytic, and the osteoblastic nature of most of them necessitate differentiation from Paget's disease.

In patients in which there is little doubt of the disease, the buffered serum acid phosphatase is useful in establishing the extent of the malignant disease as well as confirming its presence, since there is some correlation between its elevation and cancerous activity. On the other hand a normal serum acid phosphatase should never be the sole criterion for concluding that a prostatic condition is benign, since in about 20 per cent of patients with the disease the level remains normal or low even when the cancer is confirmed by other means.

Fortunately for the many patients whose

prostatic cancers are discovered too late to admit any possibility of a cure, there are definite means of prolonging their lives and relieving their discomfort, often for rather long periods of time. The basis for most of the palliative treatment of prostatic cancer is use of male and female hormones. Huggins and his associates first demonstrated a relationship between these hormones and the activity of a carcinomatous prostate about 20 years ago. The principle of hormone therapy then, as now, was the removal of the stimulation of growth by male hormones and suppression of growth with female hormones. The first aim can be accomplished surgically by orchiectomy, and the second medically, by administration of estrogen compounds. There is general agreement now[3] that greater regressions for longer periods are achieved if both methods are utilized, though complete eradication of cancer by hormonal means alone has not been reported.

The beneficial effects of hormonal treatment persist for varying periods, with most patients experiencing remissions for at least a year[5], some for as much as five years, and a few for even longer. The so-called dramatic response is felt to be due to hormone dependent portions of the tumor. Hormone sensitivity varies from part to part of the whole cancer. It appears that cell type is a factor in determining response. In spite of the hopelessness of achieving a complete cure with hormonal treatment and the certainty of eventual worsening of the disease, the alleviation of symptoms is sometimes very great. Minor obstruction due to pressure from the enlarged gland is often relieved without the transurethral resection that is otherwise necessary. Some urologists have reported that they were able to perform radical surgery after hormonal therapy, when before the prostate was immovable and quite hard. This is not justifiable if there is evidence of metastases, despite their regression with estrogenic therapy.

Either form of hormonal therapy can be used if one is precluded. Some patients with heart conditions cannot tolerate the fluid retention associated with ingestion of estrogen compounds, and for them orchiectomy alone will provide some relief. Modern diuretics may eliminate some of the problems of fluid retention. Estrogen therapy alone is available for patients who refuse surgical treatment and for those who have other conditions that make surgery too hazardous.

However satisfactory a remission has been obtained with hormonal therapy, sooner or later the original cancer begins to grow again, pain returns to metastatic areas and new metastases appear. Presumably the estrogens have lost their effectiveness because the adrenals have begun to compensate for removal of the testes or estrogenic suppression of their function by secreting more androgens. In this situation, or when the cancer is far advanced before treatment is begun at all, several possibilities are open.

After the first regression during hormonal therapy, an increase in dosage may achieve a further remission, probably for a shorter period than initially. As the dosage of estrogens exceeds the patient's tolerance, cortisone may be given to suppress the activity of the adrenals. When this fails, no routine so highly effective that it can be recommended as suitable for these types of tumors has been developed. The best that can be hoped for at this stage is a possible short remission and relief of pain in the final stages of the disease.

Bilateral adrenalectomy has been advocated, but most urologists agree that the results do not justify subjection of many patients to an operation of this magnitude with its difficult postoperative routine. Pain is relieved in about 75 per cent of all patients, and a sense of well-being is induced, without any regression of the cancer itself or prolongation of life. These results can also be achieved with cortisone, provided the dangers of prolonged use of this steroid seem justified.

Recently there have been several reports of use of hypophysectomy to decrease androgen production by the adrenals or as a final effort to prolong life following adrenalectomy. It is said to be the ultimate means of hormonal therapy, and as such has limited usefulness.

The discussion thus far has concerned antiandrogen control of prostatic cancer and its apparent shortcomings. One must remember that the original basis of endocrine therapy of prostatic carcinoma was based on

the fact that the normal gland was dependent on a constant supply of testicular androgens. If removed the prostate atrophied. Perhaps the decrease in testicular androgens renders the normal prostate susceptible to the advances of prostatic cancer. It is possibly true that male hormone rather than female hormone should be used to treat certain types of this cancer. It is true that we do not understand the biological behavior of prostatic cancer and unfortunately the same is true for other cancers.

No matter what form of hormonal therapy is used, it is a discouraging situation for the physician and patient to know before the treatment is begun that it offers no hope whatsoever of a cure. There has even been a question as to whether the increased survival time of prostatic carcinoma since hormonal therapy came into widespread use, was due to the use of hormones or to better management of the geriatric patient generally.

Radiation therapy

In an effort to improve the survival time and possibly to achieve a cure in suitable cases, a number of urologists, including our group, began to use radioactive isotopes several years ago. The results have been most promising, but there has not yet been enough time to evaluate fully this form of therapy.

The isotope of greatest value has proven to be radioactive Au 198 in a colloidal solution[4]. It is considered most suitable because of its stability, favorable half-life and low cost, and also the fact that it contains 10 per cent of gamma radiation. The use of radioactive isotopes is contraindicated when the cancer has metastasized to distant areas, but since many prostatic cancers are diagnosed before they have metastasized, and although they are unsuitable for total prostatectomy, this form of therapy may be utilized. One of the advantages of the use of radioactive substances is that the solution drains into the local lymphatic system when it is injected interstitially, and the gamma and beta rays are undoubtedly helpful in destroying many cancer cells in the area. A disappointing feature of using Au 198 is that we have been unable to distribute the isotope uniformly throughout the tissue with the result that islands of cancer cells are unaffected by the radiation. In suitable cases, however, including some in which there was no benefit from estrogen therapy, there has been a softening and shrinking of the prostate and a general improvement in the condition of the patient. In many patients treated by this method there is a very definite lengthening of the life span of the patient. In the majority of the patients we have treated with this method there has been a general improvement in health, and it is also felt that the dissemination of beta particles throughout the contiguous lymphatics of the area possibly lessens the likelihood of metastasis. Whether it proves possible to cure cancer of the prostate by use of radioactive isotopes as this method of treatment becomes more and more refined is questionable, but in our experience this method of treatment should be included in the therapeutic procedures that serve as alternatives for total cure.

Another isotope being used in the control of pain in bony metastases from prostatic cancer is radioactive phosphorus. Phosphorus is concentrated in areas of osteoblastic lesions as compared to the surrounding areas of normal bone and soft tissues. This condition presents a favorable situation for the utilization of P^{32}. It has also been shown that androgen administration enhances bone metabolism with an uptake of phosphorus up to 15 to 20 times above homogenous distribution expectation. In one series of cases[7] treated with P^{32} all patients with painful metastatic lesions to bones were markedly relieved of pain, dosages of narcotics were reduced, and some bedfast patients were even made to walk again. Although these initial studies appear encouraging and enlightening there is still much to be learned concerning the use of P^{32}.

An old concept with a new angle may possibly aid in the search for the cure of prostatic cancer. It is generally accepted as a fact that the neoplasm arises in the "outer prostate" or true gland. Androgenic hormones regulate normal prostatic growth and estrogenic hormones the growth and proliferation of the periurethral glands or benign prostatic hyperplasia. A few years ago at the University of Chicago the normal prostate gland of the rat concentrated testos-

terone labeled with carbon-14. This is a demonstration of the concentration or localization of a hormone in a target organ. These studies, while still being pursued, are just another step in the general direction. This may, however, be a real lead to a combined form of hormonal radiation control.

Aside from the diagnosis and treatment of prostatic cancer there are many other new things on the horizon of medical science. The entire field of scanning technics is progressing exceedingly rapidly. Within the next few years it is probable that the movement of fluids through the urogenital system will be visualized.

The application of the artificial kidney to segments of the human body is possibly the beginning of something really important. The work reported by the New Orleans group, showing how an isolated portion of the body was attached to the artificial kidney with the application of localized chemotherapy sounds promising.

One of the important things that seems to be happening to many physicians, especially research physicians, is that we are getting into the mental state that nothing can be done about the treatment of cancer until we know the whole story behind cancer. Brucer[6] has stated, "I should say that we are getting back to this field because people were talking the same way a long time ago. There is a statement in an unsigned editorial in the Archives of the Roentgen Ray, November, 1906, that says . . . 'There can be no proper prophylaxis until the ediology of cancer has been finally established.' This same type of thinking that nothing can be done until everything can be done is present in the current talking about the treatment of radiation damage. Some actually encourage the idea that radiation damage cannot be treated and this is doing us lots of harm. The total-body irradiation facility and whole-body counter problems, the use of chelating agents, and the use of blood replacement therapy, along with bone marrow transfusions, all have been held back by people who think these methods are no good. They are not perfect methods, but they are the best we have right now. I am inclined to think that medical scientists should stop reading newspapers on the glories of the next 50 years and go back to treating patients today. If people did not discourage us so much, we would get along a lot faster. I think one of the reasons for the constant wave of discouragement for any new idea is that we now have a group of specialists in small branches of medical knowledge, and particularly specialists in research, who know everything there is to be known. Some point out that science is dead in the United States. I do not believe this—but if medical science is sick it is not due to specialism but to the narrowness of the specalists' outlook; there is a difference between the two. I have faith, however, in the ultimate strength of man's intellect and righteousness. God willing, we will have a happier, healthier society in the forthcoming years."

Summary

Cancer of the prostate occurs very frequently in aging males but is diagnosed early enough for complete cure in a small percentage of cases. Routine rectal palpation offers the only means of consistent early diagnosis at a stage when radical total prostatectomy is successful. Hormonal therapy by means of orchiectomy and administration of estrogens and androgens is the fundamental means of palliation but use of radioactive isotopes offers promise as another form of palliative treatment and a possible curative treatment. •

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RADIOLOGIC REFLECTIONS

Shadow or substance

Marcus J. Smith, M.D., Santa Fe, New Mexico

Apothegm

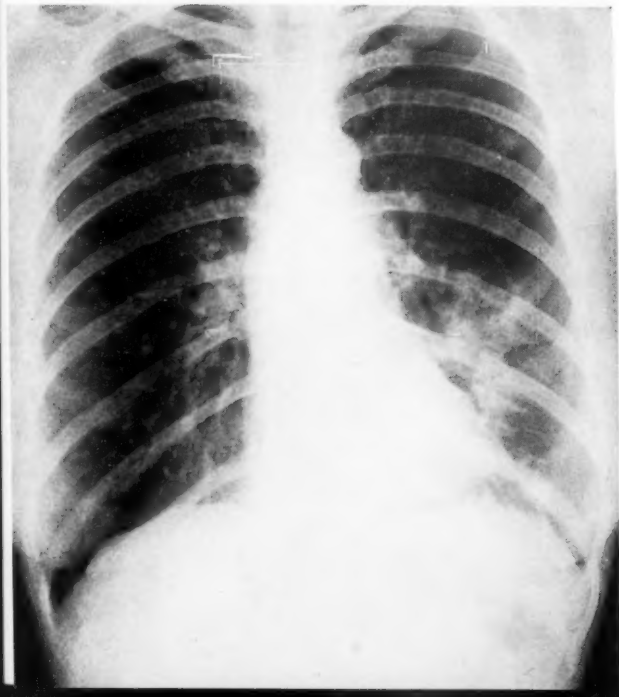
"It has often been said that there is no gain without a relative loss . . . that the physician in treating his patient can unwittingly cause disease which may be worse than the one being treated is unfortunate . . ."[1]

Clinical data

A 54-year-old housewife was seen during an attack of acute bronchitis which developed shortly after leaving a southwestern resort town famous for its dry heat. She had been harassed all of her life by bouts of asthma and bronchitis complicated by small patches of bronchopneumonia. These attacks responded promptly to various antibiotics and small doses of corticosteroids.

The long-suffering patient was again given her usual antibiotic with rapid relief ensuing, but several days later, after stopping the medications, her symptoms and fever returned. She then received full doses of tetracycline with nystatin, and prednisone, 2.5 mg., t.i.d. for three days. She again became trouble free, only to have all of her complaints recur a week later.

Fig. 1



Physical examination now disclosed signs of a bronchopneumonia at the left lung base, confirmed by an x-ray study (Fig. 1). The patchy quality of this infiltration was well demonstrated on the film and there was neither evidence of other disease nor reason to question the clinical diagnosis.

Clinical course

The patient now had massive doses of antibiotic funnelled into her, but the corticosteroids were not used. By the end of a week, she had improved symptomatically but the new chest film showed only partial resolution of the pneumonia and the physical findings at the left base posteriorly persisted for another month. At this time, an examination for acid-fast organisms was performed which eventually was reported as positive both on smear and culture. The organism was neutral red positive and peroxidase 100 per cent positive.

Streptomycin, isoniazid and para-aminosalicylic acid now began to pour through the funnel and another film made one month later showed almost complete disappearance of the lesion over the left dome of the diaphragm. The patient is now being followed closely during convalescence.

Epicrisis

Iatrogenic diseases have apparently increased in number and complexity recently, possibly paralleling the increase in the number of efficient therapeutic agents. This category of etiology must constantly be kept in mind in any diagnostic effort, even in a consideration of the commonplace pneumonia. Specifically, in a case like this, "I believe if anyone has had corticosteroids for bronchial asthma and develops a pulmonary infiltration, he should have routine sputum studies for tuberculosis."[2, 3]

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Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

A monthly news summary from the nation's capital by the Washington Office of the A.M.A.

The U. S. Chamber of Commerce and two key Congressmen, all opponents of the so-called Forand bill, recently issued separate warnings that an all-out effort will be made to get the controversial legislation through Congress next year.

In its weekly report to members, the Chamber predicted there will be "a powerful attempt" in the next session of Congress to enact the bill (H.R. 4700) which would increase social security taxes to help pay for the cost of the federal government providing surgical and hospital care for social security beneficiaries.

The Chamber warned that passage of the legislation would mark "a major break-through into the welfare state." It "probably would lead to a compulsory federal program providing complete medical care for everyone," the Chamber said.

There would be "no stopping" of such a program once it got started, the report said.

The Chamber called upon communities to find orderly solutions to the problems of the aging. Otherwise, solutions "will surely be imposed from Washington," the report added.

Similar warnings were voiced by Reps. Richard M. Simpson (R., Pa.) and Thomas B. Curtis (R., Mo.), key members of the House Ways and Means Committee, where the bill was put on the shelf last session.

Rep. Curtis urged that the medical profession and other leading opponents make a strong counter-drive in an all-out effort to block passage of the bill next session. Unless there is such action, he said he would have to "regretfully" predict that legislation along the lines of the pending bill probably will be enacted in 1960.

Rep. Simpson said that H.R. 4700, and similar legislation affecting the medical profession, "make it imperative that every doctor keep informed on legislative issues before Congress." He also urged that physicians "become patriotic political forces" by giving "their informed viewpoint" to lawmakers at all levels of government.

Rep. Simpson said it "is important" that opponents of H.R. 4700 develop "appropriate alternatives" to solve the health care needs of the aged.

He promised to continue to cooperate with the

medical profession to guard "against the disastrous consequences of compulsory national health insurance."

House Democratic Leader John McCormack of Massachusetts expressed hope that Congress next year will stamp final approval on another bill of particular interest to physicians. He praised the Keogh-Simpson bill (H.R. 10) as "meritorious legislation" and said it "should be enacted into law next year." The measure, which was passed by the House last spring but left hanging in the Senate Finance Committee, would provide income tax deferrals for self-employed persons setting aside money for private retirement plans.

A National Republican Committee on "Program and Progress" proposed a far-reaching health program to be carried out by the federal government in partnership with states and local governments.

Its goals would include: enlarging the capacity of medical schools so that 3,000 more doctors could be graduated each year, providing more hospital and nursing home beds, and supplementing hospital facilities with clinics, day-care centers and more visiting nurses to care for patients in their own homes.

The progress of medical science would be furthered by continued federal support for basic medical research. But such federal support would be given under conditions to encourage maximum non-federal spending on medical research and to prevent "too great a diversion . . . of doctors required for the equally urgent needs of teaching and medical practice." It was estimated that expenditure of $1 billion a year—equally divided between the federal government and non-federal sources—would be required by 1965.

"A free people and a free medical profession can achieve these goals with the wise support of government, without bureaucratic restrictions or interference with the physician-patient relationship which has made American health services a model for the free world," the Republican Committee stated.

The committee proposed a five-point "partnership" program: (1) short-term federal aid for construction of medical school buildings, (2) changes in the present hospital construction program to encourage renovation and repair of outmoded hospitals, (3) federal guarantees for mortgages to finance construction of private nursing homes on a basis assuring high standards of quality in construction and operation, (4) encouragement of construction of diagnostic and outpatient facilities in rural area and the building of mental health clinics, and (5) federal aid to cities "in more effective planning and coordination of health services."

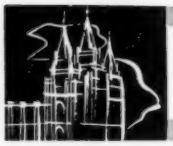
NEW MEXICO

Obituary

ALEXANDER B. LEEDS

Dr. Alexander B. Leeds, born November 4, 1876, died September 17, 1959. Dr. Leeds graduated from Baylor Medical College in 1902, and came to New Mexico in 1947 from Chickasha, Oklahoma, where he had practiced medicine for 45 years. Dr. Leeds was an internist and practiced in New Mexico for 18 years.

In May, 1954, the Bernalillo County Medical Society awarded Dr. Leeds a Fifty Years' Service Recognition Certificate.



UTAH

Obituary

E. CLARK McINTIRE

E. Clark McIntire, M.D., 61, general practitioner in the eastern portion of Washington County for the past 31 years, died September 5, 1959, at his home after an illness.

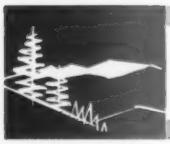
Dr. McIntire was born September 6, 1897, in Ogden, son of Joseph H. and Rose Clark McIntire. He was reared in Ogden and attended Ogden schools. On June 26, 1927, he married Annabell Sauer in Owensboro, Kentucky. He was a veteran of World War I. He received his medical degree in 1926 from the University of Louisville, Kentucky.

Dr. McIntire went to Washington County in 1927 and since that time was the only physician practicing in the eastern portion of the county.

His affiliations included the Southern Utah Medical Society, Utah State Medical Association, and the American Medical Association.

"If people want to pay me, they will," he said during his years of practice. He never mailed a bill to a patient.

He is survived by his widow of Hurricane, a son, two grandchildren, and three sisters.



COLORADO

Abstract of Minutes* House of Delegates of the Colorado State Medical Society

Eighty-Ninth Annual Session

September 8, 9, 10, and 11, 1959

Brown Palace West Hotel, Denver, Colorado

FIRST MEETING

Tuesday, September 8, 1959

Vice Speaker William M. Covode, Denver, called the House to order at 10:00 a.m. (in the Ballroom). Speaker Vernon L. Bolton and Vice Speaker Covode alternated in presiding throughout the meeting.

Dr. George Curfman, Chairman of the Committee on Constitution, By-Laws, and Credentials, stated there was no additional report beyond that published in the Handbook (page 9).

Forty-three accredited delegates (more than a quorum—before adjournment increased to 64) answered roll call.

On motion, the first report of the Credentials Committee was adopted.

Opening Address of Speaker

"I would like briefly to go over some of the things we have to do, Dr. Zarit, Dr. McDonald, and gentlemen, during the course of the meetings of the Colorado State Medical Society House of Delegates.

"At this annual session in the Fall, one of our most important pieces of business is the election of our officers for the coming year. We have several rather important committee reports to make this year." Speaker Bolton announced the following changes in appointment to reference committees:

*Condensed from the shorthand and sound-recorded record of H. E. Dennis, Certified Shorthand Reporter. Reports referred to but not reproduced herein were distributed to all members of the House of Delegates at the 89th Annual Session, in the printed "House of Delegates Handbook," or were distributed to all members of the House in mimeographed form. Copies of all such reports are on file with the Executive Office of the Society, and with the Secretary of each component society, available for study by any member of the Society.

Reference Committee on Board of Trustees and Executive Office: Dr. Howard F. Bramley, of Denver, will replace Dr. John Amesse, of Denver.

Reference Committee on Insurance and Prepayment Plans: Dr. William B. Condon, of Denver, will replace Dr. McKinnie L. Phelps, of Denver; Dr. S. C. Percefull, of Arapahoe County, will replace Dr. Frederick Tice, Jr., of Pueblo (later further revised due to Dr. Percefull's absence, and Dr. James V. Carris, of El Paso County, replaced Dr. Percefull).

"Otherwise, the committees are properly constituted for their work. We hope they will get to work today and report by tomorrow to some extent, at least.

"Several changes have come about in the last year in the operations of the House of Delegates, such as the change of the time of the First Meeting of the House at the Midwinter Session so we do meet earlier, in order to give the reference committees time to do their work. We have made a suggestion in the preface of the Handbook this year that your component societies give consideration to the possibility of paying the $5 registration fee for your delegates, for various and sundry reasons of which you are aware. We have made an attempt in the last few years to direct the work of the Ad Hoc Committee on Reorganization of the Constitution and By-Laws so as to streamline our sessions. I have nothing further of an official nature.

"I would like to express my gratitude to you, Dr. Zarit, Dr. McDonald, Dr. Wiley, the gentlemen with whom I have had the pleasure of working the last two years. It has been a pleasant duty, which I have enjoyed, and attempted to carry out to your satisfaction. Thank you."

In the absence of corrections and objections from any member of the House, the Chair declared the minutes of the February Clinical Session approved as published in the April, 1959, issue of the Rocky Mountain Medical Journal.

Speaker Bolton referred all reports of the Board of Trustees as supplemented verbally (see below) by Dr. John I. Zarit, President and Chairman of the Board of Trustees, to reference committees as noted in the Handbook.

Supplemental Report of Board of Trustees

Since the House of Delegates Handbook was printed, the Board of Trustees has held one meeting, namely on August 15. At this meeting, the Board reviewed the year's financial transactions except for the financial audit which had to await the actual end of the fiscal year. We made two minor changes in the budget for the 1959-60 year that had been previously prepared by the Finance Committee. The budget, as it appears in the Handbook, contains those corrections which were made in proof, so the budget as printed carries the approval of the whole Board. We call attention to the House, however, that this budget will need some minor amendments within the next two months to reflect the increases of both income and expense connected with the new "What Goes On" publication.

The early date of this Annual Meeting made it impossible for the accountants to complete the annual audit in time for the Trustees to review it before submitting it to the House of Delegates. We know that this year has been a very successful one financially, but the final figures are as new to us as they are to you, since they were just received this morning. The Board will review the audit at a meeting this afternoon and will take up any questions with your reference committee. If any supplemental report is indicated, we will submit it tomorrow.

At the August 15 meeting, the Board promoted Mrs. Geraldine Blackburn from the position of Executive Assistant to the position of Assistant Executive Secretary with an appropriate adjustment in her salary, and authorized the Executive Secretary to hire any additional help necessary for the operation of the Executive Office.

The Board also considered three proposals for the Society's Certificate of Service which had been received from various official sources and the Board voted to nominate two of those candidates for the Certificate.

Speaker Bolton reminded those present that all members of the Society, as well as all Delegates, were invited to appear before any reference committee to present their views with regard to reports being discussed by the reference committee.

The chair again recognized Dr. Zarit who presented two nominations on behalf of the Board of Trustees which were on motion confirmed without dissent. They are as follows:

CITATION
GENE AMOLE

Distinguished Citizen, Journalist and Radio and Television Broadcaster.

Few individuals have had as much opportunity to continually reach a large segment of a community with the spoken and written word as has Gene Amole. This opportunity to influence the public is accompanied with a tremendous responsibility.

Mr. Amole has proven throughout his 17 years of speaking to and writing for the citizens of Colorado that he recognized this responsibility. He has demonstrated a skill and rare talent for his work and has distinguished himself by wisely using his skills and talent to make a lasting contribution to his profession. In so doing, he has also made an outstanding contribution to the medical profession and to medical education in Colorado.

continued on next page

A radio career beginning at KMYR in Denver in 1942 was interrupted for three years during World War II when Mr. Amole served with the Sixth Armored Division in Europe. In 1950 he was accredited a foreign correspondent and as such did radio and newspaper work in Europe, North Africa and the Middle East. The Korean War brought Mr. Amole to the Far East where he covered the war for KMYR, 11 other Colorado radio stations and the Denver Post.

Since his return to Denver Mr. Amole has increased his influence on the public through his work in television. As writer and narrator of the television program, "Panorama," on KLZ-TV, he has made one of his greatest contributions to medicine. Practicing physicians have actively engaged in planning and producing 16 of his 120 "Panorama" programs. The excellence of the "Panorama" series has won for it the coveted Peabody Award, for outstanding local public service. The Peabody Award is the highest award that can come to a station or program in radio and television broadcasting.

Films of his heart surgery program on "Panorama" are being distributed by the American Heart Association and the Surgeon General's office of the United States Army. Both Mr. Amole and his director, Jim Lannon, received a merit award from the Colorado Heart Association for their work on this program.

Another of Mr. Amole's contributions to the medical profession is the Radio Paging System for doctors he has developed for his radio station KDEN. Through this paging, doctors are informed of their emergency calls and thus are able to give quicker service to their patients.

These and many other facts have been presented to your Board of Trustees by the Publicity Committee in support of their recommendation of Mr. Gene Amole for the Colorado State Medical Society's Certificate of Service. Your Board of Trustees agrees with the proposal and nominates Gene Amole for such a certificate.

CITATION

FREDRICK H. GOOD, M.D.

In his twelfth year as a Trustee of Colorado Medical Service, Inc., our Colorado Blue Shield Plan, and in his tenth year as President of that Plan and its Board of Trustees, Fredrick H. Good, M.D., has announced his intention to decline further nomination to this position.

With no minimizing of the importance of Blue Shield's early formative years and the excellent leadership afforded by the late John W. Amesse, M.D., the Plan's first President, and by Atha Thomas, M.D., the Plan's second President, it seems appropriate at this time to pause in recognition and appreciation of Dr. Good's services to Blue Shield and consequently to the Colorado State Medical Society.

During Dr. Good's years of Presidency, Colorado Blue Shield membership has grown from 250,000 persons to 600,000, and annual subscriber benefit payments have increased from $2,000,000 to $10,000,000. The Colorado Plan has pioneered in many benefit fields and is regarded nationally as one of the leaders in the scope of coverage offered to members. The comparative position of the Colorado Plan in the family of 74 Blue Shield Plans is dramatic evidence of the value of Dr. Good's leadership.

Out of 74 Blue Shield Plans the Colorado Plan now stands 22nd in membership size, 14th in annual volume of benefits payments, and eighth in per cent of population enrolled.

In addition to the time and energy which Dr. Good has donated locally, he has served two terms as a Trustee on the National Board as representative of this district, and one term as a Trustee at Large, elected by the National Conference of Blue Shield Plans.

One of the most significant accomplishments of Dr. Good's term as Blue Shield President has been the constant insistence on recognition of the fact that the Blue Shield Plan was and is the child of the medical profession. The liaison between the Colorado State Medical Society and Blue Shield which now exists and which has been carefully nurtured during the past decade is of utmost importance. An enumeration of the many liaison features is unnecessary—but the Fee Schedule Advisory Committee, the Adjudication Committee and the Nominating Committee are mentioned as a few examples.

The end of Dr. Good's term as President of Blue Shield is an occasion of regret to the Plan members and to the Plan's participating physicians. It is an occasion for an expression of appreciation by the Colorado State Medical Society, which can be accomplished to some small degree by awarding him the Society's Certificate of Service, and your Board of Trustees so nominates him to the House of Delegates.

(Vice Speaker Covode presiding.)

The reports of the Board of Councilors and of the Grievance Committee were referred without supplement as printed in the Handbook to the Reference Committee on Professional Relations.

Personal Report of President

It is now time for me to make my final report to you on my stewardship. This morning I feel like a medical courier who has completed the appointed rounds in one swift year. "And neither snow, nor rain, nor heat, nor gloom of night has kept him from his appointed tasks."

Despite the elements, however, it has been a most gratifying year for me. It has been a thrilling experience to have served you. I want to personally thank the staff at the State Society's headquarters for their dedication and hard work, and thereby give them the recognition they deserve. I want to pay a personal tribute to the men with whom I have served on the Board of Trustees. Their efforts, their thoughts, their ideas and their good, sound judgment, to say nothing of the many hours they have spent serving the Society away from home, cannot be equaled by any group. These self-sacrificing men serve our State Society for the good of mankind. Lastly, I extend my personal thanks to you members who have served on the various committees. You are responsbile for the satisfactory conduct of my term of office. Whatever success I have had, I owe to you.

In taking leave of this respected office, I recall the fine words of Sir William Osler: "To have striven, to have made an effort, to have been true to certain ideals—this alone is worth the struggle."

Before I hand over the gavel Friday to Dr. John L. McDonald, President for the ensuing year, I would like to make several comments, suggestions and recommendations for your serious consideration, and definite action.

It appears to me that there is a definite lack of continuity in the Board of Trustees. The Trustees, themselves, are of the same opinion. It takes a Trustee a good two years to grasp the various facets of the composition of our State Society, and it is only when he has entered into the third year that his services in performing the duties of his office have reached the maximum of efficiency. Therefore, I wish to recommend to the House of Delegates that the By-Laws be changed so that the members of the Board of Trustees shall each serve for a term of three years, and for not more than two consecutive terms, exclusive of any unexpired fraction of a term previously served.

In the past few years, several Presidents of your Society called your attention to the many responsibilities of the Presidential office, and have suggested some form of remuneration or honorarium. You referred this recommendation to the Board of Trustees for their consideration. The Board considered the recommendation and was of the opinion that remuneration was not warranted at that time. Today your President must be a Dr. Jekyll and Mr. Hyde, carrying on his private practice while assuming the responsibilities of the office of President. The high position that you bestow on a member of the Colorado State Medical Society by electing him your President is more than an honor—it is almost a full-time job. He has certain functions to perform and decisions to make almost every day. It does something to him physically, mentally and financially. I should know, and I am confident that my predecessors will concur. I have no doubt but that in the very near future an excellent candidate who should receive the honor to be selected as your President will decline because of financial reasons.

Therefore, I recommend that the House of Delegates consider favorably an honorarium for your President plus a per diem when out of the state on Colorado State Medical Society business—the Annual and Midwinter A.M.A. meetings excepted—that amount of honorarium and per diem to be determined by the Board of Trustees.

And now a question of major importance to all physicians:

The quality of medical care is of great concern to the medical profession and the general public. The labor unions, in negotiating for health-fringe benefits, have questioned the quality of medical care, and have used "poor quality of medical care" against organized medicine as a wedge to develop closed-panel practice. The medical profession from the grass-roots level up to the A.M.A., is aware of a very small percentage of doctors whose quality of medical care is below the average.

Within the past year the A.M.A. has appointed a subcommittee under the Council on Medical Services called the Medical Discipline Committee to investigate this small group of physicians. We in Colorado have attempted to clean house. Although our housecleaning has been satisfactory, there is still room for improvement. How can we keep certain doctors who are not members of the Colorado State Medical Society, and certain osteopaths, in line so that their quality of medical care can be raised to our accepted standards?

Let me present to you a recent case for your consideration. This involved surgery to a plan member of Blue Cross-Blue Shield by a physician who is not a member of the State Medical Society and whose hospital privileges—determined by his peers in that locality—do not permit him to admit patients for certain major surgical procedures. Apparently, as a means to circumvent these limitations, the physician concerned had performed a cholecystectomy with repair of umbilical hernia as an office procedure, with subsequent admission of the patient to the hospital as an emergency case for post-operative shock and subsequent post-operative care.

Since Colorado Blue Shield draws no distinction between fees to be paid for surgery in the hospital and the doctor's office, an opinion by legal counsel set forth what counsel felt was Blue Shield's legal financial obligation, which called for the regular schedule allowance. Blue Shield's lawyer was of the opinion that this case should be processed for payment, and that a letter should be sent to the President of the component medical society concerned (at that time Blue Shield did not know that that man was not a member of the county medical society) with a copy to the Chairman of the Grievance Committee, calling attention to the circumstances of the case in question, so that appropriate action may be taken.

I'm sure other prepaid insurance companies have encountered similar problems in quality care and would certainly cooperate with organized medicine to decrease the incidence of inferior medical care.

Such an offender should receive some disciplinary action. I do not believe that our Grievance Committee has such power over non-members. May I suggest that our Grievance Committee meet with the Colorado State Board of Medical Examiners and try to set up state governmental machinery for a disciplinary committee with teeth. I do believe that if a physician is placed on probation for a certain period of time with ultimate threat of losing his license to practice, he will think twice before he commits a second undesirable act of poor quality medical care.

It has been pointed out that if the medical profession had in the past discharged its responsibilities for assuring the competency of physicians, it would have prevented many of the problems existing today.

Our Colorado Blue Shield and Blue Cross now pay doctors and hospitals more than $30 million a year. Sums like these quickly establish the significance of our program. Without our Plans, many of the doctors and hospitals, as well as the

people who meet the expenses of sickness, would face calamity.

It has been a difficult year for your Blue Shield Fee Schedule Advisory Committee. They have completed their task as requested by action of the House of Delegates last February, 1959, to the satisfaction of most of the members and specialty groups. Naturally 100 per cent approval is difficult to obtain.

It has been said and it is being reiterated, that the Blue Cross and Blue Shield are the doctors' plans. This is true, but the plans belong to the subscribers and the community. Do not forget it. You and I know that almost all doctors are honest and that but a few are interested solely in money. We know that all in the health field live by ethical standards that are the highest for any profession. But does the public know this? You and I know that most hospital trustees and administrators are devoted people trying to do the best job for their community. But, here again, is the public certain of this? Frankly, the public, which you and I both serve, are raising a number of questions about hospitals and doctors. It is now asking questions about Blue Cross and Blue Shield. Some are provocative questions with overtones of disrespect for the profession which is unique in our time. The questions have been seriously raised and they come from the whole public, editorial writers, labor leaders, top management people, even from some hospital and medical people themselves. All are concerned, they want answers to their questions.

As your President, I know enough not to tell the public that it has no business asking questions. Yet, surprisingly, this is the mood of some public comments from hospital people and doctors. If the public is convinced that there is abuse of Blue Cross-Blue Shield benefits and asks questions about this, you must provide the answers. If you do not, someone will be found to get the answers for the public. Nature abhors a vacuum. If you permit a vacuum to be created, you should not be surprised at the necessity of government and its many plans moving in. You will find enough of the questions have a basis in fact which will require changes in your thought, and procedures and ideas. Ideas are today the deciding factor. The future depends on the idea that grips the minds of the millions. We are living in an ideological age. The future lies in the hands of those who know how to use ideas to win men's allegiance.

You can't defeat an idea by being Anti-It; Ignoring It; Shooting It. You can only meet an idea with a superior idea. The superior idea is "It's not who's right, it's what's right."

To accomplish this we must accept the four absolute standards:

(1) Absolute honesty. Honest apology is the highroad to lasting peace.

(2) Absolute purity. A great cleansing force through the nations.

(3) Absolute unselfishness. There is enough in the world for everyone's need, but not enough for everyone's greed.

(4) Absolute love. If everyone cared enough and everyone shared enough everyone would have enough.

In the age where we've learned to split the atom we must learn to unite humanity. It's get on together or blow up together. In any negotiation, it's not who's right, it's what's right.

Last February I keynoted my address by requesting that you consider the various problems by facing the four facts, namely, find, form, filter and face the facts. At this session of the House of Delegates, I would like to keynote your deliberations by "It's not who's right, it's what's right."

As a final request, your fullest cooperation to your new President, Dr. John L. McDonald, will be appreciated.

I hope you will continue to display the same respect to him as you have demonstrated to me. God bless you!

Speaker Bolton: Since this talk contains so very many thought-provoking suggestions for us, the Chair will take it under advisement and we will divide it up among the several reference committees covered in this report, and will bring it out for further consideration and action by the House. (The recommendation concerning terms of Trustees and question of an honorarium for the President was referred to the Reference Committee on Board of Trustees and Executive Office; that portion concerned with Blue Cross-Blue Shield was referred to the Reference Committee on Insurance and Prepayment Plans.)

No other personal reports were submitted by any Society officer.

The printed report of the Delegates to the American Medical Association, together with the following verbal supplements, was referred to the Reference Committee on Public Relations.

Supplemental Reports of A.M.A. Delegates

Kenneth C. Sawyer: "I want to thank you for the opportunity to supplement the two reports we have submitted to you since the annual meeting. Actually that was a very productive meeting. We are deeply grieved, nauseated and disgusted with the misrepresentations, inaccurate and harmful press coverage of the proceedings of that meeting. It is typical of the treatment free enterprise and basic traditions of the free world are receiving from many of our newspapers today. I think that the Denver Post attempted to correct their error. May I say almost nothing reported by the press concerning the actions of the House of Delegates was factual. I do not know how long the people of our country in organized medicine are going to stand still and tolerate this. If you will bear with me, I would like again to correct some of the misrepresentations in the newspapers, and please, for your own satisfaction, read the actual proceedings as printed in the Journal of the American Medical Association:

"(1) Colorado has never disapproved of group practice.

"(2) There has been no shakeup in the A.M.A. top leadership except the annual election of officers, most of whom were holdovers from the previous year and were re-elected.

"(3) The A.M.A. has never had an all-out hostility to prepaid health insurance plans on a free choice of physician basis. In other words, we have encouraged all free enterprise prepaid health insurance plans. So to put the newspapers straight: How could the national organization drop a hostility which never existed? The House action neither harmed nor strengthened organized medicine's stand regarding the free choice of physicians.

"Regarding our own Colorado problem, the battle is almost won. The United Mine Workers' policies and practices have been condemned and disapproved on three occasions at the annual meetings. Organized medicine agrees that this outfit is detrimental to the patient, to the practice of medicine, and to the security of our nation. With your help and suggestions we will go forward in Dallas in December."

E. H. Munro: "I looked around and didn't see Ken Sawyer here and that is the reason I stood up to make a report.

"I was going to say virtually the same thing he did.

"I realize there are a good many people in this group that were disappointed and dissatisfied, and even critical, of what we accomplished at the Atlantic City meeting. We were instructed to go back there and particularly obtain disapproval of the report of the Committee on Medical Care Plans. This, of course, you realize we did not succeed in doing. But we did succeed in having it not approved, which is a very different thing from the way the newspapers reported it as having been accepted and approved. Immediately after that action by the House there was a motion that the officers of the A.M.A. should insure that the press got this thing straight, and they were told that this report was accepted for information only, but was not approved. We were unable to carry out the directive of this House of Delegates. We went back there in force. We had the three delegates and three alternates, your President, Vice President, and President-Elect, a couple of members of your Board of Trustees, and two Council members. You had two men that were hand-picked because of their knowledge of the problem and because they were forceful speakers. These men all worked on this thing. Colorado had traditionally carried the fight on this free choice matter through the years.

"You will note that the resolutions that have gone in have come from Colorado. The strategy and organization and plan for carrying this thing out has been from Colorado headquarters. We have had meetings with some of our friends from other states to plan the campaign. Colorado had resolutions some years ago directing an educational program on free choice. That was not forthcoming and they were finally, through the efforts of Colorado, directed to get at it. They have been goaded sharply by Colorado and others since then.

"There was a lot of inertia to overcome in this ponderous body, and I think it finally got moving. Probably all of you are aware of a meeting that was held here in this room, a two-day regional conference on insurance and prepaid medical plans. That was authorized by the American Medical Association. We had the Trustees of the A.M.A., the Vice Speaker of the House, several members of their Council, and 10 members of the A.M.A. staff here; and there were representatives from Kansas, Wyoming, Utah, Arizona, New Mexico, and Colorado. But, far more important than that, there were businessmen and laymen. There were representatives of the Chamber of Commerce, of the American Farm Bureau Federation, a number of Presidents and Vice Presidents and high executive people of some of the large insurance companies. Of course, that is the hand-picked group. They are people who believe in freedom, and yet they are laymen. They are the kind of people who should hear and did hear and take part in discussion on the principle of free choice.

"So some of the efforts that Colorado has put forth on this matter of free choice are bearing fruit.

"I oughtn't sit down without mentioning the fact that on the 17th of July one of your members appeared in Washington and testified before the House Ways and Means Committee giving our arguments against the Forand Bill."

Reports of standing committees

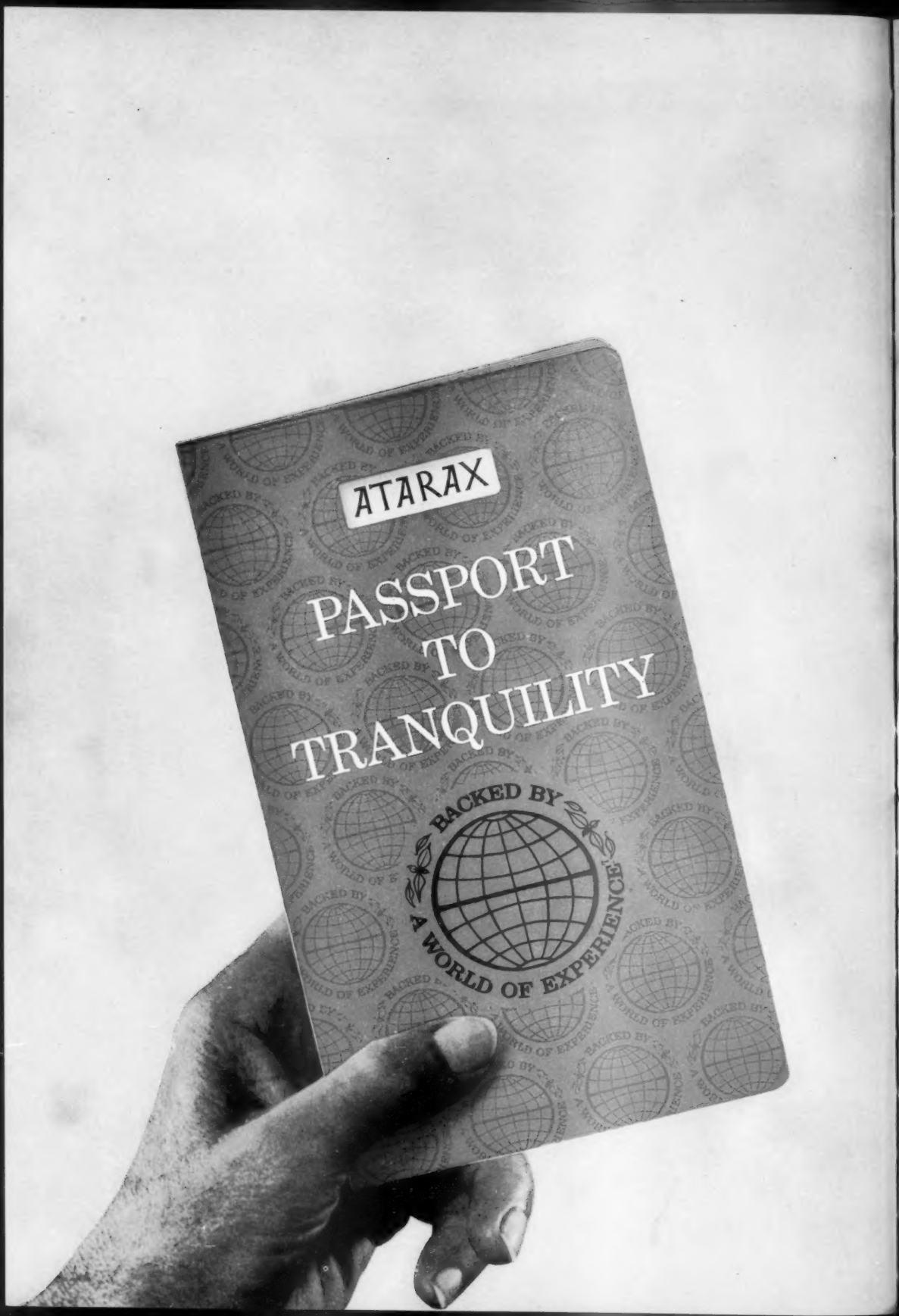
Reports of standing committees were referred as indicated in the Handbook without supplements (unless otherwise noted below).

Supplemental Report—Subcommittee on Prepayment Services

Dr. George Buck, Chairman of the Committee on Medical Service, presented the following supplemental report which was referred to the Reference Committee on Insurance and Prepayment Plans:

The Subcommittee on Prepayment Services met with representatives of the Colorado Dermatologic Society and the Colorado Medical Service on Wednesday, August 26, 1959, to consider the letter from the Colorado Dermatologic Society regarding the Blue Shield $25 deductible rider for office care. It was the opinion of the Colorado Dermatologic Society that this plan would cause undue bookkeeping expense, and they recommended initially that this be changed from the present plan to a plan whereby the patient would be reimbursed,

continued on page 112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☞ **added frontiers of usefulness**

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Supplied: Tiny 10 mg., 25 mg., and 100 mg. tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

References: 1. Farah, L.: Internat. Rec. Med. *169*:379 (June) 1956. 2. Smigel, J. O., et al.: J. Am. Geriatrics Soc. *7*:61 (Jan.) 1959. 3. Feinberg, A. R., et al.: J. Allergy *29*:358 (July) 1958. 4. Eisenberg, B. C.: J.A.M.A. *169*:14 (Jan. 3) 1959. 5. Maryssael, L.: Bruxelles-méd. *38*:141 (Jan. 26) 1958. 6. Pfleger, R.: Med. Klin. *53*:1030 (June 5) 1958. 7. Over 200 laboratory and clinical papers from 14 countries.

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rather than payment being made directly to the physician as is true under this rider and all other Blue Shield plans. This matter was discussed thoroughly and the Blue Shield representative asked that they be given one year's trial of the present plan without change. The representatives of the Colorado Dermatologic Society agreed to this recommendation and it was agreed that the matter should be reconsidered after everyone concerned had had a year's experience with it. A quorum of the subcommittee on prepayment services was not present, so no official action of the subcommittee was taken.

THEODORE K. GLEICHMAN, M.D.
Chairman, Subcommittee on
Prepayment Services.

Supplemental Report—Subcommittee on Blood and Tissue Banks

Dr. Rettberg presented the following communication directed to S. M. Prather Ashe, Chairman, Subcommittee on Blood and Tissue Banks. This report was referred to the Reference Committee on Legislation and Public Relations.

Letterhead of The Belle Bonfils Memorial Blood Bank, 4200 East Ninth Avenue, Denver, 20, Colorado. September 2, 1959.

At the September, 1958, meeting of the Colorado State Medical Society held at the Broadmoor Hotel in Colorado Springs, the Belle Bonfils Memorial Blood Bank was reaffirmed by the House of Delegates to be the official blood bank of the Colorado State Medical Society. The House of Delegates and various committees which considered the matter of blood banking in general instructed me to continue with the educational and teaching program of the blood bank. This service has continued and is offered free for residents in various specialties in the practice of medicine and for qualified medical technologists.

We were also asked to serve various walking blood banks throughout the state and these have been contacted and the problem reviewed with those in charge. Two communities have increased their panels with our administrative guidance and performance of the technical work. Another community has established a walking blood bank with our counseling and suggestions.

We were asked to furnish blood throughout the state of Colorado whenever and wherever possible and to establish branch blood banks in communities who asked for this service.

We were also asked to continue serving the state and country through clearinghouse utilization. By using the clearinghouse, patients in Colorado are able to receive blood credit from their friends and relatives residing in various parts of the country, and, conversely, residents of Colorado can transfer credit from Denver to recipients of blood residing in other states. Since January 1, 1959, the following transactions have been completed: a total of 326 units of whole blood have been shipped and 1,517 paper credit transactions have been handled. Patients receive credit on their blood accounts for these transactions although no shipment of blood is involved.

1. For out-of-state service through the clearinghouse, 97 units of whole blood were shipped to San Francisco, Oakland, Bakersfield, Santa Rosa, Fresno and Burlingame, California, and 858 paper credit transactions have been handled.

2. Outlying areas of Colorado served directly, not through the clearinghouse, have requested and had sent to them 223 units of blood. Among the receivers are Pueblo, Fort Collins, Boulder, Loveland, Colorado Springs, Morrison, Del Norte, Glenwood Springs and Aspen. There were, in addition to the shipment of blood, 659 paper credit transactions for Colorado.

3. Out of the state of Colorado, but in the area served by Denver, are Riverton, Wyoming, and Sidney, Nebraska, who have requested and received six units of whole blood.

We have been formally requested by the Loveland Memorial Hospital to establish a blood bank there under the supervision of their pathologist. This service was begun July 1, 1959.

We were also advised at the 1958 meeting to further promote a blood service plan whereby families or individuals could secure protection against their possible use of whole blood. This was established as of August 1, 1958, and is known as the Rocky Mountain Blood Service Plan. The Blood Service Plan encompasses 3,637 individual memberships and 2,110 family memberships as of July 31, 1959. Since the plan's inception, 172 units of blood have been used by 68 of the total memberships. The plan is still not of sufficient magnitude to pay its own way, and, since its inception, we have incurred a total loss of $7,000. With the plan's growth in the last three months, we feel that we shall reach the break-even point about August 1, 1960.

Respectfully submitted,
William A. H. Rettberg, M.D., Director.

cc: Martin E. Anderson, Jr., M.D.
Gifford V. Eckhout, M.D.
Stanley K. Kurland, M.D.
George S. Tyner, M.D.
Floyd J. Bjork, M.D.

The report of the Public Health Committee and all subcommittees was referred to the Reference Committee on Public Health, as printed, as supplemented by the following proceedings and discussion.

Supplemental Report—Subcommittee on Tuberculosis Control

Dr. John Zarit presented the following supplemental report.

The report of the Tuberculosis Control Subcommittee of the Public Health Committee appears on page 45 of the Handbook. For your information, I wish to convey to you the thoughts of Governor Steve McNichols. I was in his office on another matter a week ago yesterday and he thanked the Task Force Committee on Tuberculosis Control, for submitting the interim and long-range program. Your President was chairman of that committee. He made this statement to me:

"If your T.B. Control Committee or the State Medical Society wishes to submit any proposed legislation pertaining to the interim or long-range report, let me know, and I will back you to the fullest extent. Furthermore, if you have any non-legislative problems to consider, particularly on the means test, to circumvent that until that is decided upon—" Please discuss it with him and he will back us to the nth degree.

Vice Speaker Covode referred the published report of the Public Policy Committee, together with the following supplement, presented by Dr. John I. Zarit, to the Reference Committee on Legislation and Public Relations.

Dr. Zarit: All of you have received the mimeographed copy of the letter addressed to The Honorable Stephen L. R. McNichols, Governor of Colorado, by Dr. J. Lawrence Campbell, Chairman of the Public Policy Committee (a copy thereof is attached hereafter) with which 14 recommendations were submitted to the Governor relating to the mental hospital at Pueblo. This report, gentlemen, demonstrates sound reasoning, mature judgment, and statesmanship, in the way this thing has been handled. As a result of this report, Dr. Cleere and I were asked to be present at a conference with the Governor which took place a week ago yesterday. If the Governor knew how the State Society felt and if he could have gotten to us, he never would have asked for a task force committee to be formed and come up with their recom-

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mendations. He had no idea how he could really approach the State Medical Society. He was so appreciative of this report, and he told us in person and Dr. Cleere will vouch for it, that he has no desire of asking for Dr. Zimmerman's resignation, and that this committee had certain functions to perform and he did not feel that he should interfere with the Task Force. He realized that our committee with their recommendations did not approve the "pilot study." Personally, perhaps he doesn't approve it, either. But this committee acted so fast that within a week after it was formed it rushed to the Legislature and got them to approve the pilot study and appropriate a certain sum of money. The Governor therefore must carry out the wishes of the Legislature on this pilot study.

Now, whether it will be good or not, he feels it ought to be given a trial. He was very much interested in this report and he would like to meet with representatives of the State Medical Society to consider the appointment of a head over all the institutions and for other personnel. He showed his sincerity. I received a letter from him on the 4th of September, dated September 3rd, and let me read it to you:

"Dear Dr. Zarit: I want to acknowledge with appreciation and thanks the report from the Colorado State Medical Society and its Public Policy Committee on the operations of the Colorado State Hospital at Pueblo. Please accept and extend my gratitude for this comprehensive and well-prepared report to Dr. J. Lawrence Campbell, Chairman of the Society's Public Policy Committee, and to the committee of senior psychiatrists who prepared the investigations and recommendations, namely, Dr. Franklin G. Ebaugh, Dr. Bradford Murphey, Dr. E. James Brady, and Dr. Francis A. O'Connell. I am happy to learn of the willingness of the Society to offer this broad cooperation to the State of Colorado in meeting this pressing problem. I will welcome the Society's appointment of representatives to meet with us, both with particular reference to implementing the projected program for the hospital as well as to assist in the specific job of securing a competent professional staff for the state hospital and for the state mental health program. I think that the State Society should be congratulated on the type of work performed by this committee."

The door is open to the official chambers of the Governor and I think it is the first time that any Governor has gone so far as Governor McNichols has in asking the cooperation of the State Medical Society. (Applause.)

The report of the Rocky Mountain Medical Conference Committee was referred as printed to the Reference Committee on Scientific Work, with the following verbal supplement presented by Mr. Sethman:

Harvey T. Sethman: Mr. Speaker, on behalf of the Rocky Mountain Medical Conference Committee, I presented their resolutions to the Nevada State Medical Association House of Delegates in Reno two weeks ago, and, I am happy to report to you, without a dissenting vote the Nevada State Medical Association voted at that time to join the Rocky Mountain Medical Conference, and adopted a duplicate resolution which has been passed by each state medical society now in the conference, including, of course, your own Colorado House of Delegates in 1937.

Reports of all special committees were then referred as printed in the Handbook, with supplements as follows:

Supplemental Report of the Blue Shield Fee Schedule Advisory Committee

Mimeographed copies of this supplemental report were distributed to all members of the House and are on file in the Executive Office.

A motion by Dr. Rettberg seconded and carried without dissent that a minority report of Dr. Mahony's be presented at this session, whenever it is obtained.

Speaker Covode recognized Dr. Robert Bosworth to discuss the supplemental report of the Blue Shield Fee Schedule Advisory Committee.

Dr. Bosworth: Mr. Speaker, I am speaking sole-

ly as an individual, but I believe this has some direct bearings on the deliberations of the reference committee in considering the Blue Shield Fee Schedule Advisory Committee report. I am speaking to something which I feel personally very strongly, and, as I stated before, I am speaking as an individual and not representing anyone but myself.

This has nothing to do with the amount of professional fees, but rather the principles upon which fees have been and will be based if the proposed plan and plans are passed by this House.

I refer to the income level basis of the Blue Shield Insurance Plan. I do not believe any of us have disagreed violently with the service benefit income limit so long as this has been commensurate with an income which implies some difficulty in handling medical and professional fees, etc.

However, with an income limit going to the amount proposed in the high plan, $9,000, a few of us can imagine many patients who will not be or who will not claim to be within this service benefit level of $9,000. My question is: What will the effect of this be?

This for all practical purposes fixes a doctor's fee for about 80 per cent of the patients, the percentage depending, of course, on the economic condition in the state. It means someone else is telling a doctor what he may charge and only what he may charge with this 80 per cent, approximately, of our practice, regardless of his professional status or experience, especially the time in the area, the confidence of the patients, etc.

Do we want our successors, our friends, our sons, to enter a field or a profession where individuality and professional integrity are being whittled at and carved away? Do we want to regiment ourselves in this way—despite all we believe—so that state-controlled medicine has only to step in and say in effect, "You doctors think this is adequate in your form of comprehensive medical care"? I beg to submit that it is not a comprehensive plan and it is not an equitable plan, in all respects, regardless of great strides and the great bulwark it has been in the field of voluntary insurance. To me it is like an insiduous malignancy, this $9,000 in the proposed plan. It has been lower in the past, as you know. Perhaps $12,000 to $15,000 in three to five years, and up and up. Regardless of how you look at it, it is fixing a fee by someone even if we are in essence doing it ourselves. Thank you very much.

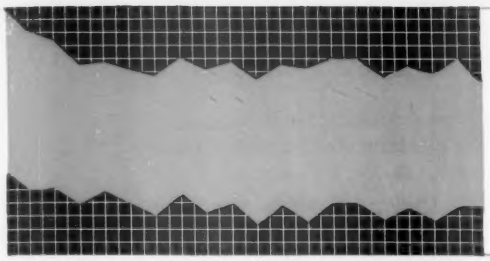
There was no further discussion and the subject was referred to the Reference Committee on Legislation and Public Relations.

This concluded the presentation of annual reports, so far as the Chair was informed.

(Speaker Bolton presiding.)

Speaker Bolton: I should like to clarify for some of the chairmen the reference of some of

continued on page 120



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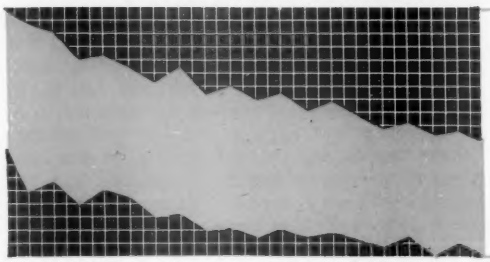

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Organization cont. from page 117

these reports. Going back to page 34 in your Handbook, under the report of the Committee on Medical Service, Subcommittee on Emergency Medical Service will be referred to the Reference Committee on Board of Trustees and Executive Office. On page 35 of the Subcommittee on Physician-Nurse Relationship, will go to the Reference Committee on Professional Relations. Medical Care of Veterans, no reference. Professional Insurance, no reference. Report of the Subcommittee on Blood and Tissue Banks, just given, will go to the Legislation and Public Relations Reference Committee. The other report given, on Prepayment Services, will go to the Reference Committee on Insurance and Prepayment Plans. Indigent Medical Service, no reference.

I think the rest of those references are clearly outlined in the book. Therefore, the next order of business is unfinished business remaining from previous sessions of the House.

(Mr. Sethman reported there was none.)

New business

The following were elected to the Nominating Committee:

Samuel B. Childs, Denver
H. B. Huskey, Mesa
J. B. Farley, Pueblo

John A. Davis, Arapahoe
Winthrop B. Crouch, El Paso
William R. Sisson, Otero
William Curtis, Boulder

Resolutions introduced
American Medical Education Foundation Committee

Chairman Frank E. Stander presented an award of merit from the American Medical Association Educational Foundation to the Mesa County Medical Society, and this was accepted by Dr. H. B. Huskey, delegate from Mesa County Medical Society.

Resolution by the Colorado Society of Internal Medicine

The following presentations submitted by Dr. William A. H. Rettberg, Delegate from Denver, were referred by Speaker Bolton to the Reference Committee on Insurance and Prepayment Plans:

Dr. Rettberg: Mr. Speaker, Mr. President, Mr. President-Elect, and Delegates.

I should like to preface my remarks by telling you that as of September 4, 1959, the Colorado Society of Internal Medicine has officially withdrawn as participating physicians in Blue Shield. Undoubtedly this is a widely-known fact to most of you. I do not want anybody to think that this is a dogmatic and split decision of the Executive Committee at all. Our latest tally on this shows that 90 people concur in this opinion and there are six who are against it. You may want to know how many members compose our society. There are about 190, which is, after all, a small segment of physicians practicing in Colorado, less than 10 per cent. This notification, however, has formally been received by Blue Shield and we have received a reply. This is the resolution, Mr. Speaker. It is addressed to Vernon L. Bolton, M.D., Speaker of the House of Delegates, 89th Annual Session, Colorado State Medical Society, dated September 4, 1959:

RESOLUTION

WHEREAS, The Colorado Society of Internal Medicine has long recognized and supported the Community Service and Fee for Service principles as exemplified by Colorado Medical Service, Inc. (Blue Shield), and

WHEREAS, The Colorado Society of Internal Medicine has likewise recognized that such plans as devised by Colorado Medical Service were, in fact, originally developed and subsequently improved primarily for the care of catastrophic and surgical illnesses which represent but a portion of the ills with which individuals are afflicted.

The Colorado Society of Internal Medicine further recognizes the more recent and earnest attempts made to remedy the deficiencies in rendering more complete nonsurgical prepayment care by Colorado Medical Service, but contends that such efforts have been ineffectual, and

WHEREAS, The Colorado Society of Internal Medicine submits that the problems involved in producing both effective surgical and nonsurgical care through a prepayment mechanism differ widely and are not comparable; that it is perhaps presently impossible to devise a satisfactory fixed fee schedule for nonsurgical care.

The Colorado Society of Internal Medicine holds that when either surgical or nonsurgical service is rendered on a prepayment basis which is fair and equitable for but one type of such service, the other is bound to suffer. This will inevitably result in dissatisfaction with, abuse and deterioration

continued on page 124

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pyrilamine maleate	12.5 mg.)
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Terpin hydrate	180 mg.
APAP (N-acetyl-p-aminophenol)	325 mg.

References: 1. Lhotka, F. M.: Illinois M. J. **112**:259 (Dec.) 1957. 2. Fabricant, N. D.: E.E.N.T. Monthly **37**:460 (July) 1958. 3. Farmer, D. F.: Clin. Med. **5**:1183 (Sept.) 1958. 4. Bonica, J. J.: in Drugs of Choice, Mosby, St. Louis, 1958, p. 272. 5. Dascomb, H. E.: in Current Therapy, Saunders, Phila., 1958, p.78. 6. Bickerman, H. A.: in Drugs of Choice, Mosby, St. Louis, 1958, p.547.

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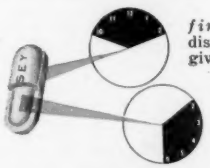

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of the plan; increased cost to both plan and subscriber; and, ultimately, in decreased quality of service to that subscriber. The contemplated additional plans only compound present inequities.

RESOLVED, therefore, That the House of Delegates of the 89th Annual Session of the Colorado State Medical Society both endorse and support the principle that nonsurgical medical care as rendered be compensated for on a co-insurance basis with the elimination by Colorado Medical Service of any fixed fee schedule for such service; and that, if it concurs, said House of Delegates direct the proper authorities of Colorado Medical Service to implement this principle.

Respectfully submitted,
ROBERT V. ELLIOTT, M.D., Secretary

Dr. Rettberg: Here is a communication from the Colorado Springs Society of Internal Medicine which President-Elect Dr. John McDonald, from Colorado Springs, one of our group, has asked me to read.

Thomas H. Mahony, Jr., M.D.
1801 Williams Street, Denver, Colorado.
Dear Dr. Mahony:

At a meeting of the Colorado Springs Society of Internal Medicine on September 3, 1959, the following resolution was passed. The Society wishes to request your presentation of this resolution to the Subcommittee on Blue Shield of the House of Delegates of the Colorado State Medical Society.

The Colorado Springs Society of Internal Medicine reaffirms the resolution stated by the Colorado Society of Internal Medicine as pertains to action taken by that Society on August 27, 1959. We urge withdrawal of our members as participating physicians in the Colorado Medical Services, Incorporated. We urge re-exploring a realistic fee schedule for nonsurgical illnesses.

As a representative of the internists in the state on this committee, we appreciate your efforts in our behalf.

J. ROWLAND REID, M.D., Secretary,
Colorado Springs Society of Internal Medicine

Dr. Rettberg: The Colorado Springs Society of Internal Medicine is our largest component society, composed of 30 members.

The foregoing resolution and correspondence were referred to the Reference Committee on Insurance and Prepayment Plans.

Sam W. Downing, Denver, Chairman of the Reference Committee on Professional Relations, presented the following resolution, which was referred to the Reference Committee on Board of Trustees and Executive Office:

RESOLUTION

WHEREAS, The administrative details connected with medical practice increase in volume and complexity each year; and

WHEREAS, The proper functioning of various committees prevents many members from attending clinical and social events; be it

RESOLVED, That the Program Committee of the Colorado State Medical Society be asked to provide a full day which may be devoted to the Society's business, so that meetings of boards, councils, and committees may conflict as little as possible with clinical and social functions.

Dr. R. B. Richards presented the following resolution forwarded from the Morgan County Medical Society, which was by Speaker Bolton referred to the Reference Committee on Insurance and Prepayment Plans.

"The following resolution regarding the Colorado Old Age Pension Medical Plan was adopted at the regular meeting of the Morgan County Medical Society, September 1, 1959, for presentation to the Colorado State Medical Society Annual Meeting:"

RESOLUTION

WHEREAS, The Colorado State Welfare Department has been designated by state law to set up and supervise the Old Age Pension Medical Care Plan and has authority to determine all administrative policies;

WHEREAS, The Welfare Department has been seeking the advice and cooperation of the Colorado State Medical Society and has Blue Cross and Blue Shield administer the Plan;

WHEREAS, The Old Age Pension Medical Care Plan contracts will be soon subject to renegotiation;

WHEREAS, This would be the ideal time to consider the entire Old Age Pension Medical Care Plan and its relationship to the medical profession;

WHEREAS, There is much dissatisfaction among many members of the Colorado State Medical Society regarding administrative policies of the Pension Medical Care Plan; be it

RESOLVED, That the House of Delegates of the Colorado Medical Society directs the Society officers, Board of Trustees, the Public Policy Committee, and other committees connected with the Medical Care Plan to very diligently and carefully negotiate with the Colorado State Welfare Department regarding the Old Age Pension Medical Care Plan, and that before final acceptance of the plan they contact all component societies to obtain their advice and recommendations, and that they especially work to change the items listed in the following discussions:

(1) The payment of office calls and house calls should be abandoned permanently for the following reasons:

a. The cost to Blue Shield and to the doctor's office of administering these claims is out of proportion to their size.

b. This type of payment invites abuse. Many pensioners are using these authorized calls simply because they want to use them up and not because of medical need.

c. The average pensioner who only requires a few office or house calls every three months is not suffering any financial hardship and does not need help from the pension medical plan. On the other hand, the pensioner requiring extensive out-patient care with multiple office or house calls may be completely unable to meet his financial obligation and the payment of a few calls by the medical plan is only a drop in the bucket for him. It would be much more sensible not to waste the pension medical fund on multiple small payments and divert the money to help out the pensioner who is really financially heavily burdened. It is probable

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that more patients who are not quite sick enough to really need hospitalization could be kept at home if they could be assured of better financial support in an expensive illness.

(2) Provision should be made for paying out-patient laboratory work-ups. Money from the house call-office call funds could very wisely be diverted to this use for the following reasons:

a. Pensioners often do not realize the value of diagnostic tests and are unwilling to spend the necessary money.

b. The expense of these tests can be very burdensome to the pensioner.

c. Since the fees involved are greater, the administrative expense is proportionally down.

d. This would take much of the pressure off of the physician who is being pressed to put the pensioner in the hospital for diagnostic work (this at least doubles the cost). Of course, the physician is not supposed to yield to such pressure, but, influenced by the cost of out-patient diagnostic procedures, the pensioner usually, rather suddenly, becomes too ill to remain at home and the doctor would really be asking for trouble if he failed to hospitalize anyone of this age who said he was too ill to remain at home.

(3) Doctors should be allowed to determine their own fees. Theoretically all pensioners are screened and supposedly have no resources above the income ceiling. In practice this very often is not the case. Many pensioners at their family's expense and request have the best private rooms and unnecessary private nurses. The doctor in the same case is expected to give first-rate medicine for second-rate fees. Some pensioners have money and/or private insurance they have specifically laid aside for paying a full and just fee—this is discouraged by the present policies. In the past 99 per cent of fees have been satisfactorily worked out between the doctor and his patient, why would this system be drastically changed to control the 1 per cent?

(4) In regard to hospitalization, administrative offices should not be asked to nor allowed to exercise medical judgment. This is the very essence of our quarrel with socialized medicine. It is certain that the pension medical care plan will never be able to pay for unlimited hospitalization but the limit on hospitalization can be best set by simply saying we allow so many days. This only requires a simple, clerical decision to decide when eligibility is gone. Under the present system a request for extension is reviewed by the administrative office which decides whether the patient they have never seen really needs more hospitalization—that is a medical decision requiring medical judgment.

(5) The amount of money spent on drugs should not be limited by forbidding certain drugs. The amount should be limited by setting a maximum amount requiring a simple, clerical decision, and not by forbidding certain drugs which requires medical judgment, and by somebody who has not been treating the patient. The forbidden steroid may be just as lifesaving to one patient as is the antibiotic for another, yet the latter has all of his paid for, the former none of his. Let's just pay for part of each.

(6) The payment plan for nursing home medical care should be drastically changed. The present system is nothing but old-fashioned piecework. The doctor is paid so much for the first piece and so much for each additional piece. He is allowed only so many pieces per month unless he applies for more, in which case an administrative office exercises medical judgment and permits or denies additional pieces that month.

Speaker Bolton asked Dr. Mahony, who had come in, to present his minority report.

Thomas A. Mahony, Jr., M.D. (Not a member of the House): "Gentlemen, my apologies for being late. This is a minority report from the representative of the Colorado Society of Internal Medicine on the Blue Shield Fee Schedule Advisory Committee, addressed to the House of Delegates, dated September 8, 1959:

Subject: Minority report from the representative of the Colorado Society of Internal Medicine on the Blue Shield Fee Schedule Advisory Committee.

To: The House of Delegates, 89th Annual Session of the Colorado State Medical Society.

In accordance with the request of the Colorado Medical Service, Inc., for a fee schedule, the Colorado Society of Internal Medicine has submitted two proposed fee schedules for the "Preferred A" Plan. This society indicated its dissatisfaction with the present Preferred Plan allowances and attempted to correct the problems in the allowances provided by the new plan. The first proposal was submitted on February 12, 1959. This constituted a fee schedule which the Colorado Society of Internal Medicine believes to be fair for compensating the internist for in-hospital care of his patient. It also urged the study of co-insurance and/or deductible plans for nonsurgical care. The Colorado Medical Service offered a counter-proposal based on the Massachusetts Blue Shield Plan which offers additional allowances for care of patients with certain specific diseases. The Colorado Society of Internal Medicine rejected this counter-proposal and reaffirmed its first proposal.

The second proposal, based on the first, was submitted on May 20, 1959. In this, the Colorado Society of Internal Medicine stated its belief first in the need for recognition by Blue Shield of specialty qualifications and specialty care in all fields in its fee allowances and, second, that a dual or differential fee schedule on the basis of specialty qualifications is essential if Blue Shield is to continue to serve the subscriber as the subscriber expects and deserves to be served. The Colorado Society of Internal Medicine suggested that this type of coverage could be offered through the sale of a specialty care rider which would apply to all specialty care, both surgical and nonsurgical. This would not disturb the structure or operation of present Blue Shield procedure. It also urged once again the study of co-insurance and/or deductible insurance coverage for nonsurgical care.

This second proposal was presented to the full Blue Shield Fee Schedule Advisory Committee at its meeting on May 23, 1959. In spite of previous remarks of the President of the Colorado State Medical Society, the Advisory Committee felt that it should express a formal attitude on the proposal and, on motion duly seconded and passed, referred the matter to a committee to be selected by the chairman of the Advisory Committee.

This special advisory committee met on July 11, 1959. The first item on the agenda was the consideration of the Colorado Society of Internal Medicine proposal. The chairman, Dr. John Amesse, announced that this proposal could not be discussed because of a mandate from the President of the State Medical Society and the Board of Trustees ordering that it be rejected. The undersigned, representing the Colorado Society of Internal Medicine, protested this summary dis-

missal of the proposal and requested a motion and vote. The proposal was rejected in this vote, the undersigned opposing the rejection, and the proposal was not further discussed in any way.

Subsequently, on August 15, 1959, the Blue Shield Fee Schedule Advisory Committee approved a fee schedule for medical care including the provisions of the Massachusetts Plan which had been specifically rejected by the Colorado Society of Internal Medicine.

As a result of this failure of the Blue Shield special committee to grant a hearing to this proposal and to report on it to the full advisory committee and as a result of the substitution of a fee schedule which is not acceptable to the Colorado Society of Internal Medicine, the Executive Committee of the Colorado Society of Internal Medicine met on August 27, 1959, and resolved (1) to urge its membership to withdraw immediately as participating physicians in the Colorado Medical Service, Inc., and (2) to urge the House of Delegates of the Colorado State Medical Society to explore co-insurance plans and other measures for realistic compensation of nonsurgical care.

The Colorado Society of Internal Medicine believes that the refusal of the Blue Shield Fee Schedule Advisory Subcommittee to discuss any specific proposal because of mandate from a duly elected official of the Medical Society is improper.

The Colorado Society of Internal Medicine does not condemn Blue Cross and Blue Shield but takes its action in recognition of the fact that the subscriber is inadequately covered for specialty care of nonsurgical illness in the presently existing fee schedules. The Society of Internal Medicine does not wish to commit itself to perpetuating in the proposed new plans the inequities which exist in the present plans.

Speaker Bolton referred the above minority report submitted by Dr. Mahony to the Reference Committee on Insurance and Prepayment Plans.

John I. Zarit (President and Chairman of the Board): I would like to make one correction to the report submitted by Dr. Mahony: When the Blue Shield Fee Schedule Advisory Committee met to consider the mandate of the House of Delegates last February, it was to come up with proposals and changes of fee schedule on the Preferred A and the Standard A plan; but the preferred plan was to be left alone. Some of the specialty groups wanted some changes in the preferred plan. It was the understanding then that the preferred plan should not be touched.

Mr. Sethman made routine announcements concerning the duties of reference committees, and verified attendance with respect to members of the various reference committees, and announced time and place of meetings of those committees.

Delegate John A. Davis (Arapahoe): Would a motion be in order to appoint a substitute Delegate from Arapahoe County since one of our Delegates and his Alternate are unable to attend today?

Speaker Bolton: It has to be by action of your county society. You can confer with your county society and report back to us, by wire or telephone, but it has to be by action of your county society.

Vice Speaker Covode declared the House to be in Executive Session, the proceedings of which were not recorded. He appointed Drs. Curfman and Amesse to act as Sergeants-at-Arms, and directed them to clear the room of all persons except those entitled to remain during the Executive Session. Dr. J. C. McAfee was not present and the House without dissent voted to seat his alternate, Dr. Freeman Longwell.

Vice Speaker Covode then proceeded to caution members of the House concerning the secrecy of an Executive Session and the House was in Executive Session for a brief period, at the conclusion of that session, being no objection, the Chair declared the House again in open meeting and requested the Sergeants-at-Arms to open the doors.

Speaker Bolton announced that Robert O. Beadles would replace Dr. Alson F. Pierce, of El Paso, on the Reference Committee on Professional Relations; and then announced, at 12:15 o'clock p.m., September 8, 1959, that the House was adjourned, or in recess, until 4:30 o'clock p.m., September 9, to reconvene in the same room (the Grand Ball Room of the new Brown Palace West).

SECOND MEETING

Wednesday, September 9, 1959

Speaker Bolton called the House to order at 4:30 o'clock p.m. The roll call disclosed 70 accredited members of the House present, more than a quorum. (Later in the meeting this was revised to 73.)

At the conclusion of the roll call, Chairman Curfman of the Credentials Committee reported, recommending the seating of Dr. John C. Straub, Jr., as substitute Delegate from the Eastern Colorado Medical Society. On motion the supplemental report of the Credentials Committee was adopted.

Upon motions regularly seconded and carried without discussion or dissent, the following, as well as others later in the meeting, were seated:

Dr. James M. Perkins, of Denver, Alternate for Dr. Ervin A. Hinds.

Dr. George S. Tyner, of Denver, Alternate for Dr. Howard T. Robertson.

In the absence of objection by any member of the House, and on motion regularly seconded and carried without dissent, the House dispensed with the reading of the Condensed Minutes of the First Meeting of the House at the 89th Annual Session.

Supplemental Report of the Board of Trustees

The following supplemental report presented by Chairman John I. Zarit was adopted without dissent:

The Board convened at 4:30 p.m., on September 8, 1959, and reviewed the annual audit prepared by the firm of Collins, Peabody, Masters and Vanderlaan.

The Board approved the audit and reports the financial condition of the Colorado State Medical Society to be excellent.

Supplemental Report of the Board of Councilors

Chairman Herman W. Roth presented the following report which was adopted without dissent:

Supplementing our report as printed in the Handbook, the Board has further considered the problems relating to professional association with non-M.D.'s referred to in the first paragraph of that report and has arrived at the following decision:

The Board of Councilors doubts that the University of Colorado can properly deny to any person licensed to practice medicine the privilege of attending postgraduate courses in medicine.

It is the opinion of this Board that teaching or attendance at any such postgraduate course by a member of this Society therefore does not constitute a voluntary association professionally with cultists as prescribed by Section 3 of the Principles of Medical Ethics.

Referring to the second paragraph of our report as published in the Handbook, the Board has met jointly with the Board of Censors of the Denver Medical Society, the Constitution, By-Laws and Credentials Committee of this Society, and others, and has reaffirmed its decision arrived at at the Clinical Session in February and communicated to the Denver Medical Society under the date of March 10. Further, the Board has suggested to the representatives of the Denver Medical Society and the Constitution, By-Laws and Credentials Committee that the section of the By-Laws relating to Active Junior Membership be clarified, and we are informed that the Constitution and By-Laws Committee has already undertaken such work.

Referring to the third paragraph of our Handbook report, the Board has determined that it cannot reopen the disciplinary case tried by the Board in 1955.

After consultation with the Constitution, By-Laws and Credentials Committee, the Board has fixed the jurisdictional area of the proposed Adams County-Aurora Medical Society as requested in the Constitution of the proposed society, namely, the County of Adams and that portion of Arapahoe County now or hereafter embraced within the corporate limits of the City of Aurora, Colorado. The By-Laws of the State Society automatically grant the privilege to the new society, when chartered, to waive jurisdiction over the western section of Adams County as may be mutually agreeable to that society and the Clear Creek Valley Medical Society.

HERMAN W. ROTH, M.D., Chairman

Personal Report of President

President John I. Zarit: Merely for your information, you will recall I read the letter from Governor McNichols yesterday in reference to the mental health situation. My secretary received a call from his office yesterday while we were in session. The call was from Mr. Daily, the public relations man, and one of the secretaries of the Governor. He called in regard to two questions:

(1) Mr. Daily wrote the letter over the Governor's signature. The purpose of the letter was that the State Society was to back Dr. Zarit up. The subject of the letter: The Governor would welcome the opportunity of using the State Society in choosing physicians for the state hospital. Mr. Daily would like to know if the letter was adequate. They are really going all out.

(2) This is really at the insistence of some of the officers of the State Society. The Governor

would also like to know if Dr. Zarit would be willing to serve on the new committee the Governor is setting up to be known as the Committee on Aging. I guess this will have to do with the 1961 White House Conference. Mr. Daily again notes that this is not the same committee as that set up by Ed Johnson in 1956. The committee will take up such problems as convalescent home care, hospitalization, treatment in the home, and other similar problems affecting the aged. Some of the members have urged me to accept but I shall defer that for a few more hours.

Introduction of guests and distinguished visitors

At this point in the proceedings Speaker Bolton called upon Executive Secretary Sethman to introduce visiting dignitaries and guests.

Mr. Sethman introduced those visiting Executive Secretaries from other states who were present, including Mr. Arthur R. Abbey, Cheyenne; Mr. Harold Bowman, Salt Lake City; Mr. Ralph R. Marshall, Albuquerque; Mr. L. R. Hegland, Billings, and Mr. Roy Ragatz, Assistant Executive Secretary of the Wisconsin State Medical Society. He also introduced Dr. Wesley W. Hall, of Reno, President-Elect of the Nevada State Association; Dr. Lewis M. Overton, of Albuquerque, President of the New Mexico State Medical Society; and Dr. Ulrich R. Bryner, of Salt Lake City, President of the Utah State Medical Association.

Speaker Bolton then asked Drs. Hall, Overton and Bryner if they would care to make any comments.

Dr. Hall: Mr. Speaker, members of the House of Delegates, and guests. This is certainly a privilege to be able to be with you again and to observe your proceedings here. I want to particularly thank your excellent Executive Secretary for opening the door for us in Nevada to participate in the Rocky Mountain Medical Journal. Also two weeks ago, as Mr. Sethman has told you, he was so gracious to invite us to this great Rocky Mountain Medical Conference which our House of Delegates unanimously accepted and approved.

I do not know whether you gentlemen realize it or not, but it has been my observation that a prophet is not without honor save in his own backyard. Having served in the House of Delegates of the American Medical Association for probably all too long, I think I have had the privilege and opportunity to observe where the leadership comes from in these United States of America. It isn't necessarily from the largest states, not by any means. I have been particularly impressed with you gentlemen from Colorado. Yours is an outstanding medical society. You are dedicated to the practice of medicine. Above all, you are dedicated to the principle of the free choice of physician. I commend you for this. But, above all, you are gentlemen of courage. You have your own problems certainly. We are not particularly jealous of you. We certainly have admiration for you. We want you to keep up the good work. We are behind you. We still look forward to you for leadership, even more so than from many of the much larger states.

Dr. Overton: Mr. Speaker, President Zarit, members of the House and guests. I particularly want to express my appreciation at being here today. I would also like to echo what Dr. Hall has just said.

New Mexico has probably looked upon Colorado as our godfather, and possibly upon Harvey Sethman as our godmother.

Actually, we do not wish to be thought of as cockier but we have taken a lot of the good things that you people have developed. Your courage certainly has been exemplified in the steps you have taken. I think you are accomplishing much more in the progress of medicine than some of our larger states.

We are going to continue to look forward to you for help. We hope that some of these days we may grow up so that we may be of help to you.

President Bryner of Salt Lake City, Utah, and President-Elect Benjamin Gitlitz, of Thermopolis, Wyoming, were not present in the room when called upon to speak by Speaker Bolton.

Reports of the Reference Committees

Vice Speaker Covode proceeded to call for reports of reference committees, which follow. In each case they were presented by the chairman of the committee, and on his motion adopted with-

out dissent section by section and as a whole, with certain exceptions as hereinafter noted, after opportunity was afforded for discussion, and were declared to be adopted by the Speaker or Vice Speaker who at times alternated in the proceedings.

Board of Trustees and Executive Office

(a) Your reference committee recommends the approval of the report of the Board of Trustees as carried on pages 10, 11, 12, and 13 of the Handbook and to the middle of page 14 of that Handbook. In reviewing the report, the committee reviewed the supplemental report of the Board of Trustees and recommends its approval.

(b) The reference committee wishes to compliment the Finance Committee on its excellent work in the past year, and its achievement of $11,000 surplus as shown by the audit and the $2,000 added to the Journal Reserve Fund; and last, but not least, no extra assessment is foreseen in the near future.

Your reference committee recommends the approval of the reports of the various subcommittees of the Board of Trustees, as printed on pages 15, 16, 17, 18 and 19 of the Handbook. A new agreement was sent to the Board of Trustees by Mr. J. Peter Nordlund, our present attorney counsel, stating his individual requests and specific remunerations. These various requests and the report were reviewed by the committee and accepted for this fiscal year and the next fiscal year, as requested by Mr. Nordlund in his report.

(c) Your reference committee recommends approval of the report of the Foundation Advocate as printed on pages 25 and 26 of the Handbook.

(d) Your reference committee reviewed the portion of President Zarit's Address of Welcome given on September 8, regarding the obtaining of some form of remuneration or honorarium for incoming Presidents, and wishes to submit to the House of Delegates for its serious consideration that Presidents (not Presidents-elect) will receive $200 per month as an honorarium as well as $100 per diem when on out-of-state business—the annual and midwinter A.M.A. meetings excepted. We feel that this is a compulsory move so as not to lose any confidence in future Presidents because of financial reasons.

(e) The second portion of President Zarit's talk pertaining to the Board of Trustees serving for two terms of three years was examined, and found to be not feasible since it would require the revising of the Constitution and By-Laws. The committee did not recommend approval of this portion of Dr. Zarit's request.

The budget for the fiscal year was examined and accepted by your reference committee.

(f) A resolution submitted by Dr. Sam Downing, requesting that the Program Committee of the Colorado State Medical Society be asked to provide a full day which might be devoted to the Society's business so that meetings of Boards, Councils and Committees may conflict as little as possible with clinical and Society functions, was reviewed. Your reference committee wishes to recommend that this resolution be referred to the Board of Trustees without recommendation since this would require an extra day for our medical meetings.

ROBERT LUDWICK, M.D., Chairman
VICTOR A. CRUMBAKER, M.D.
TERRY J. GROMER, M.D.
JACKSON SADLER, M.D.
MILTON L. WIGGINS, M.D.

Speaker Bolton: With reference to item (d), the Chair would like to ask one question to be certain that the House is clear on this particular point: Does this mean now that you are giving this as a directive to the Board of Trustees to implement this as a suggestion?

Chairman Ludwick: Yes.

There was no further discussion and the remaining sections and the report as a whole were adopted.

Report of Reference Committee on Legislation and Public Relations

(a) Your reference committee recommends the approval of the report of the Liaison Committee to the Board of Regents as carried on pages 20 and 21 of the Handbook, and wishes to compliment the committee, the Board of Regents, and Dean Glaser on the adoption of this resolution.

(b) Your committee recommends approval of the report of the Subcommittee on Blood and Tissue Banks as printed on page 35 of the Handbook, and also on the supplemental report which was read at the first meeting of the House. We feel the entire Society has greatly benefited from the educational and teaching program of the Belle Bonfils Memorial Blood Bank and we wish to commend them once again on their outstanding work.

(c) Your committee recommends the approval of paragraph 1 of the report of the Public Policy Committee appearing on page 46 of the Handbook. No action was taken on the problems of the Old-Age Pension Plan as it now exists and although we are cognizant of its defects, this matter is being handled by another reference committee.

(d) Your committee approves paragraph 2 of the report of the Public Policy Committee as appearing on page 46 of the Handbook, and feels that the Public Policy Committee should be commended for its liaison with the Governor in the appointments to the State Board of Medical Examiners.

(e) Your committee has studied and discussed paragraph 3 of the Public Policy Committee report and your reference committee wishes to commend Drs. Ebaugh, Murphey, Brady, and O'Connell for their extensive and painstaking study of the care of the mentally ill in the State of Colorado. Your committee feels that the existing facilities for the mentally ill should be expanded and improved, together with adequate personnel, prior to the launching of any long-range program. This is a reiteration of the stand of the House of Delegates at the February, 1959, session of the House. It is the opinion of the committee that the report of the Consulting Committee of Senior Psychiatrists to the Public Policy Committee of the State Society contains many excellent suggestions and proposals that should be strongly considered when practical. We wish to commend Dr. Zimmerman and his staff for their years of excellent service in the face of many handicaps.

(f) Your committee recommends the approval of paragraphs 4, 5, 6 and 7 of the report of the Public Policy Committee as appearing on pages 46 and 47 of the Handbook.

(g) Your committee recommends the approval of the report of the Subcommittee on Publicity as printed on pages 47 and 48 of the Handbook. We feel that Dr. Bouslog and his committee have done outstanding work in presenting

medical productions and information to the public.

(h) Your committee recommends the approval of the report of the Advisory Committee on Workmen's Compensation Affairs as printed on page 50 of the Handbook, and in particular recommends that the Orientation Course should include in the curriculum instructions regarding the legal requirements of Workmen's Compensation cases.

(i) Your committee recommends the approval of the report of the Advisory Committee to the Colorado Association of Medical Assistants as appearing on pages 51 and 52 of the Handbook.

ROBERT E. McCURDY, M.D., Chairman
M. L. CRAWFORD, M.D.
FRANK E. STANDER, M.D.
LEO J. NOLAN, M.D.

Report of the Reference Committee on Scientific Work

(a) Your reference committee recommends the approval of the report of the Committee on Library and Medical Literature, as carried on pages 32 and 33 of the Handbook.

(b) Your committee recommends approval of the report of the Committee on Medical Education and Hospitals as printed on page 33 of the Handbook.

(c) Your committee recommends the approval of the report of the Committee on Rocky Mountain Medical Conference as printed on pages 48-49 of the Handbook.

(d) Your committee recommends approval of the report of the Committee on Scientific Program as printed on pages 49 and 50 of the Handbook, and wishes to extend our appreciation to Smith, Kline and French for their fine part in our program. The reference committee also wishes to commend the committee for their fine work during the whole year.

JAMES KENNEDY, Chairman
EDWARD C. BUDD, M.D.
WM. A. H. RETTBERG, M.D.

Report of the Reference Committee on Public Health

(a) Your reference committee has read the report of the Subcommittee on Alcoholism and Drug Addiction as it appears on page 37 of the Handbook, and recommends commendation of that committee and suggests they continue their good work.

(b) Your reference committee has read and approved the report of the Automotive Safety Subcommittee as given on pages 38 and 39 of the Handbook, and recommends that they continue their efforts during the next year.

(c) The Public Health Reference Committee has approved the report of the Cancer Control Subcommittee as printed on page 39 of the Handbook, and we recommend that the activities of the Cancer Control Subcommittee and the Cancer Conference Subcommittee be incorporated into those of one committee to be called the "Cancer Committee."

(d) Your reference committee has read and approved the report of the Cancer Conference Subcommittee as carried on page 39 of the Handbook.

(e) The reference committee has approved and commends the Subcommittee on Aging whose report is carried on page 40 of the Handbook.

(f) The reference committee has approved the report of the Immunization Committee, listed on page 40 of the Handbook, and recommends increased activity on the part of all private physicians and public health personnel to further the process of immunization of our population against polio.

(g) The Public Health Reference Committee has read and approved the report of the Industrial Health Committee as carried on page 41 of the Handbook. We approve the organization of a Rocky Mountain Industrial Health group and would recommend that the House of Delegates approve the organization of this group.

(h) The reference committee has read and approved the report of the Subcommittee on Maternal and Child Health as given on page 41 of the Handbook.

(i) Your Reference Committee on Public Health considered the report of the Mental Health Subcommittee and we wish to approve the recommendation given in subparagraph (1) of Section 1 in the report of the Mental Health Committee, as carried on page 42 of the Handbook; that is, that the Mental Health Bill regarding certifying psychologists be opposed until further study is accomplished.

(j) The reference committee did not approve subparagraph (2) of Section 1 of this report, and recommends to the House of Delegates that this subparagraph be disapproved and the following subparagraph substituted in its stead:

"Your reference committee questions whether this is a propitious time to seek any amendment to the Medical Practice Act. We recommend that any review of the Medical Practice Act should be conducted only under the guidance of the Legislative and/or of the Public Policy Committees."

(k) The reference committee approves the section No. 2 of the report of the Mental Health Committee, as printed on page 42 of the Handbook, dealing with problems of the State Hospital at Pueblo, with the following exception: (1) We recommend that the balance of paragraph 2, beginning with the words "Selection of a Director" at the top of page 43 be deleted and the following substituted for it: "Selection of a Director of Psychiatric Services should be made by a committee, appointed by the Governor, to include members recommended by the Colorado Neuro-psychiatric Society, the Colorado State Medical Society, and the district branch of the American Psychiatric Association. This position should remain an appointive one." (2) Paragraphs 3 and 4 below this as given on page 43 in the Handbook are approved as written.

(l) Your reference committee has read and approved the report of the Committee on Rehabilitation.

(m) Your reference committee has read and approved the report of the Subcommittee on Rural Health and wishes to commend them for the large amount of work that is being done by this committee.

(n) Your reference committee has read and approved the report of the Subcommittee on Sanitation. We recommend that the Sanitation Committee continue its efforts to promote a consolidated sewage plan for the Denver-Clear Creek Valley area.

(o) Your Reference Committee has studied the report to the Governor by the Task Force Committee on Tuberculosis Control, and recommends its approval by the House of Delegates. Your reference committee approves the balance of the report of the Tuberculosis Control Subcommittee, as given on page 45 of the Handbook.

WILLIAM LEWALLEN, JR., M.D., Chairman
LEE J. BEUCHAT, M.D.
GEORGE R. BUCK, M.D.
EDWARD MEISTER, M.D.

Report of the Reference Committee on Miscellaneous Business

(a) Your reference committee recommends the approval of the report of the American Medical Education Foundation

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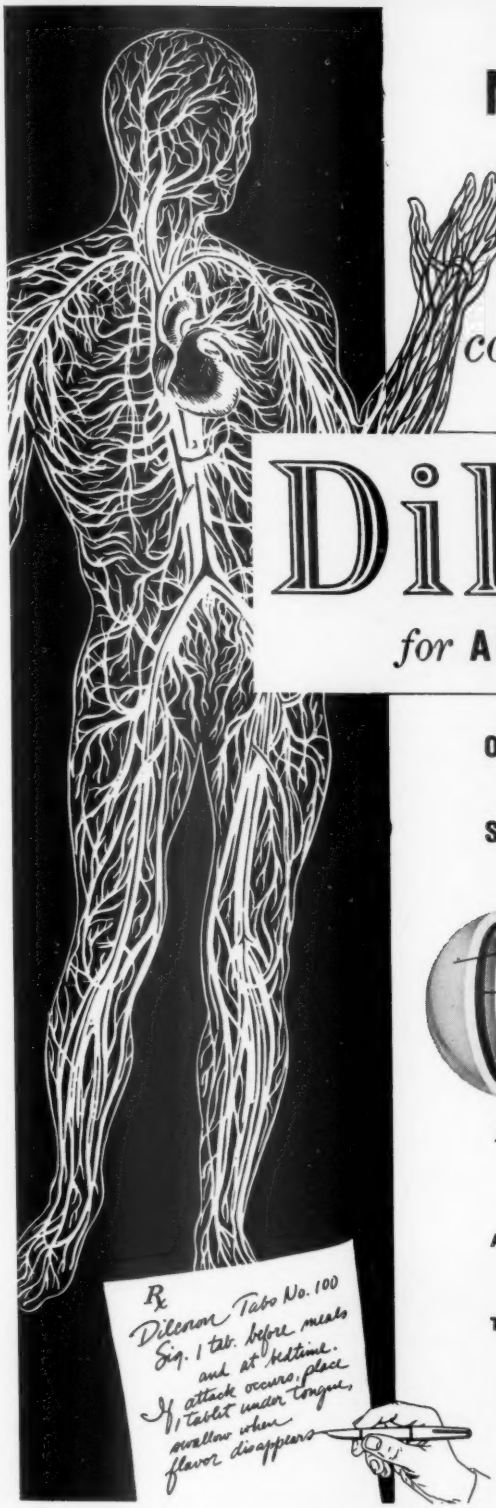

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ORAL *(tablet swallowed whole)*
for dependable prophylaxis

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for immediate and sustained relief

Nitroglycerin
—0.4 mg. (1/150 grain)—acts quickly

Citrus "flavor-timer"
—signals patient when to swallow

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—15 mg. (1/4 grain)—prolongs action

For continuing prophylaxis patient swallows the entire Dilcoron tablet on an empty stomach.

Bottles of 100.

Average prophylactic dose:
1 tablet four times daily
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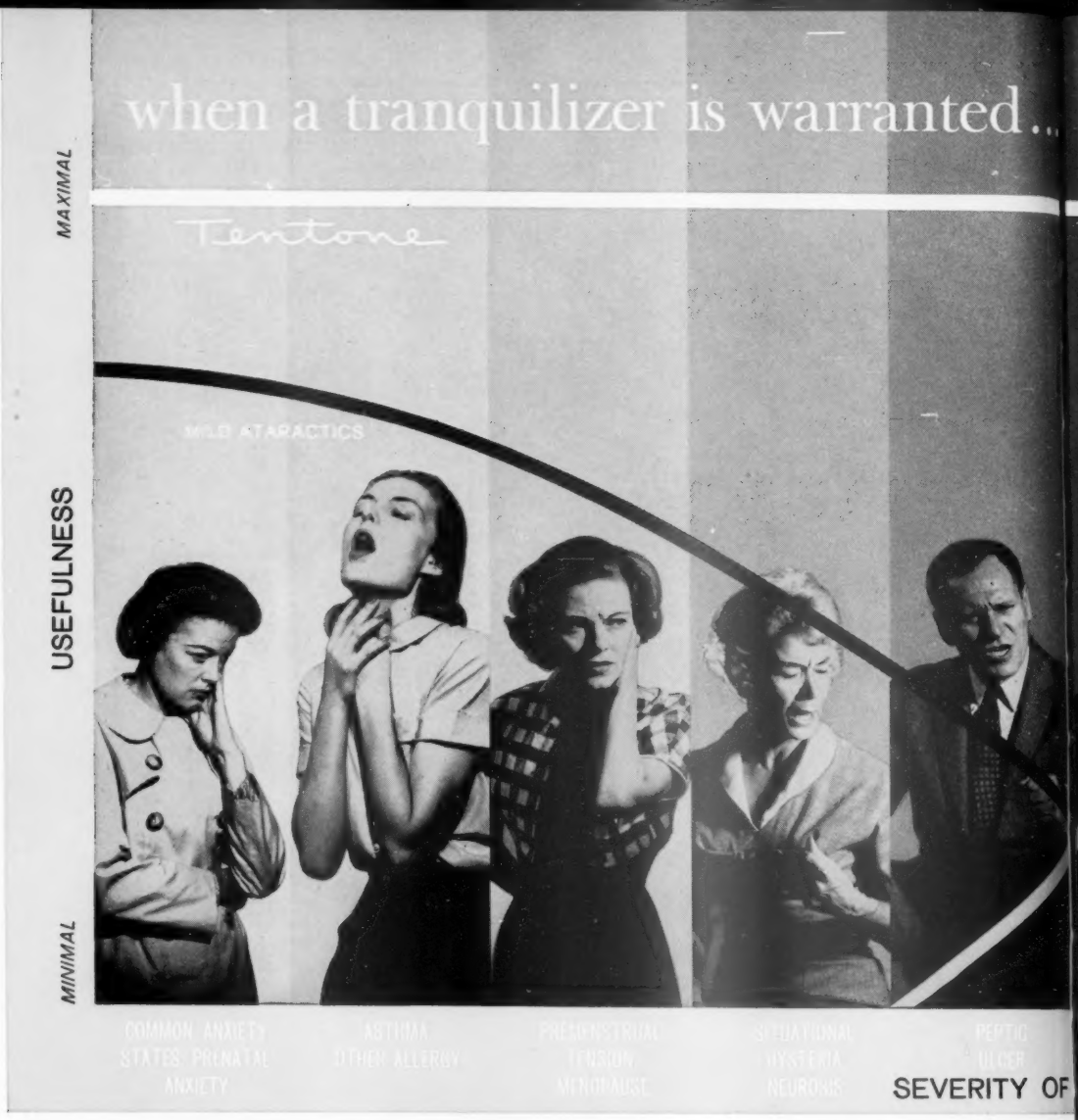

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1. Bodi, T., and Levy, H.: Clinical report, cited with permission. 2. Wetzler, R. A., and Phillips, R. M.: Clinical report, cited with permission. 3. Prigot, A.: Clinical report, cited with permission. 4. Gosline, E., *et al.*: *Am. J. Psychiat.* 115:939 (April) 1959. 5. Turvey, S. E. C.: Clinical report, cited with permission.

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Organization cont. from page 134

Committee as carried on page 53 of the Handbook and that the committee be commended for its fine work in this important endeavor.

(b) The committee wishes also to add its congratulations to Mesa County for their fine response, which won them the AMEF award of merit.

(c) Your reference committee recommends the approval of the report of the Military Affairs Committee as carried on page 62 of the Handbook.

(d) Your reference committee recommends the approval of the report of the Representatives of the Adult Education Council as carried on page 62 of the Handbook.

M. A. DURHAM, M.D., Chairman
VINCENT G. CEDARBLADE
L. L. HICK
H. B. HUSKEY
C. H. McLAUTHLIN
J. H. PATTERSON

Report of Reference Committee on Constitution, By-Laws and Credentials

(a) Your reference committee has reviewed the report of the Ad Hoc Committee on By-Law Revisions as published on pages 53, 54, and 55 of the Handbook, and the supplement to the report of the Ad Hoc Committee on By-Law Revisions as published on pages 55 through 62 of the Handbook. The committee recommends that they be submitted to the Board of Trustees for further study. It is further recommended that the Board of Trustees again refer this matter to the House of Delegates at the Interim Session in 1960. Your committee believes that this sweeping revision of our governmental structure is not well enough understood by the House of Delegates for action at this time. The revision would be of primary advantage to the executive functioning of the Society, particularly in the way of streamlining such functions. There is question as to whether such changes would actually correct existing deficiencies in our mode of operation, and the Board of Trustees should be given the opportunity to evaluate such proposed changes.

(b) Your reference committee has reviewed the application of a new component of the Colorado State Medical Society, the Adams County-Aurora Medical Society, and has approved the Constitution and By-Laws submitted by that component society. The committee recommends the establishment of the Adams County-Aurora Medical Society.

(b) Misunderstanding has arisen over the definition of the membership classification, "Active Member Junior." To clarify this misunderstanding, your committee recommends a change in the By-Laws by deleting paragraph b, Section 3, Chapter I, page 10 of the Articles of Incorporation, Constitution and By-Laws, and substituting for it the following:

"b. Active Members Junior. Active Members shall be accorded this classification for a total period of three years of active medical practice, whether continuous or interrupted by military service or additional formal training—specifically, full-time A.M.A. approved internship, residency, fellowship or preceptorship. Any period of active medical practice in any locality will be included as a part of the three-year period of eligibility for Active Junior Membership. Active Members Junior may not be required to pay annual dues or assessments in an amount to exceed one-half the dues or assessments charged against Active Members Senior."

GEORGE CURFMAN, M.D., Chairman
WINTHROP B. CROUCH, M.D.
JOHN A. DAVIS, M.D.
H. HARPER KERR, M.D.

Paragraph (a) of the above report was discussed by Vice Speaker Covode, Chairman Curfman and the Secretary, Mr. Sethman, for purposes of clarification, after which it was decided to defer action on this paragraph until the third meeting of the House of Delegates. The remainder of the report was adopted without discussion or dissent.

Report of the Reference Committee on Professional Relations

(a) Your reference committee recommends the approval of the report of the Board of Councilors as carried on page 23 of the Handbook, and wishes to express the appreciation of the Society for the excellent manner in which they have discharged their duties.

(b) Your reference committee recommends the approval of the report of the Grievance Committee as carried on page 24 of the Handbook, and wishes to express the appreciation of the Society for their many hours of work.

(c) Your reference committee recommends approval of the report of the Subcommittee on Panel Practice as printed on page 24 of the Handbook, and wishes to commend the entire committee, and Dr. B. T. Daniels, its Chairman, particularly, for their fine efforts. In addition, the reference committee agrees that the Subcommittee on Panel Practice should be continued as suggested in this report.

(d) Your reference committee recommends the approval of the report of the Delegates to the American Medical Association as carried on page 25 of the Handbook, and of the supplemental reports. The committee would like to compliment the Delegates and Alternates for the manner in which they conducted themselves at the meeting in Atlantic City, particularly regarding the "Report of the Commission on Medical Care Plans." The reference committee would like to call attention to the fact that again the actions of the Medical Society have been reported in a grossly inaccurate fashion by the press. It is the understanding of the reference committee that the local press was acting on national press releases and perhaps could be at least partially absolved from this criticism. However, this reference committee would like to again call the attention of the House to the fact that the reporting of medical matters is often grossly inaccurate. The committee would like to call attention to the leading editorial in the July issue of the Rocky Mountain Medical Journal entitled "Misinterpretation of Doctors' Shop Talk."

(e) Your reference committee has studied the report of the Subcommittee on Emergency Medical Service as carried on page 34 of the Handbook. It recommends approval of the section (a) of this report and recommends that sections (b), (c), (d), (e), and (f) be accepted but not approved by the reference committee. The reason for non-approval of these sections is that the reference committee did not have enough information concerning these sections to recommend approval.

(f) Your reference committee recommends the approval of

the report of the Subcommittee on Physician-Nurse Relationship as listed on page 35 of the Handbook.

(g) Your reference committee recommends the approval of the report of the Medicolegal Committee as it appears on pages 36 and 37 of the Handbook, and wishes to commend the committee for the important and constructive work it has done. In addition, the committee wishes to take note of Dr. Bluemel's study of medicolegal statistics and wishes to thank him for his constructive efforts in the medicolegal field.

(h) Your reference committee was asked to consider Dr. Zarit's suggestion in his address of September 8: "May I suggest that our Grievance Committee meet with the Colorado State Board of Medical Examiners and try to set up state governmental machinery for a disciplinary committee with teeth." Your reference committee suggests that since state governmental machinery in this area is controlled by the Medical Practice Act and as such is not under our direct influence, the Grievance Committee be charged with the responsibility of reporting immediately to the State Board of Medical Examiners any complaints which are received against physicians who are non-members of the Society, and thus are not under the jurisdiction of said committee. The reference committee further recommends that there be the closest possible liaison between the Grievance Committee and the State Board of Medical Examiners.

SAM W. DOWNING, M.D., Chairman
JOHN B. FARLEY, M.D.
ALEXIS E. LUBCHENCO, M.D.
EDWARD E. MUELLER, M.D.
WILLIAM Y. TAKAHASHI, M.D.

Report of the Committee on Nominations

The following report of the Nominating Committee, presented by Chairman John B. Farley, not subject to adoption, was received and placed on file.

Your Committee on Nominations respectfully offers the following slate of nominations for positions to be filled by election at this 89th Annual Session of the Colorado State Medical Society:

For President-elect: Dr. C. W. Anderson of Denver.

For Vice President: Dr. J. Alan Shand of La Junta.

For Treasurer, three-year term: Dr. W. C. Service of Colorado Springs.

For Trustee, three-year term: Dr. Carl H. McLauthlin of Denver.

For Councilor, District No. 2, three-year term: Dr. John Simon of Englewood.

For Councilor, District No. 5, three-year term: Dr. Herman W. Roth of Monte Vista.

For Councilor, District No. 9, three-year term: Dr. Scott Gale of Pueblo.

For members of the Grievance Committee, each for a two-year term, six to be elected: Dr. Harper Kerr of Pueblo, Dr. John W. McDonald of Sterling, Dr. Joel Husted of Boulder, Dr. James Orr of Fruita, Dr. Paul Tramp of Loveland, Dr. Theodore Gleichman of Denver.

For member of the Grievance Committee, one-year term, to fill vacancy created by resignation of Dr. Robert C. Lewis, Jr.: Dr. R. L. Speck of Cortez.

For Delegate to the A.MA.., two-year term: Dr. E. H. Munro of Grand Junction.

For Alternate Delegate to A.M.A., two-year term: Dr. Harlan E. McClure of Lamar.

For Delegate to the A.M.A., two-year term: Dr. I. E. Hendryson of Denver.

For Alternate Delegate to A.M.A., two-year term: Dr. Clare C. Wiley of Longmont.

For Foundation Advocate: Dr. W. W. King of Denver.

For Speaker of the House of Delegates: Dr. William Covode of Denver.

For Vice Speaker of the House of Delegates: Dr. Heman R. Bull of Grand Junction.

For the place of the 93rd Annual Session to be held in 1963: Pueblo.

JOHN B. FARLEY, Chairman
SAMUEL B. CHILDS
H. B. HUSKEY
JOHN A. DAVIS
W. B. CROUCH
W. R. SISSON
WILLIAM CURTIS

Upon completion of the committee reports above, Chairman Bolton introduced Mr. Rupert Brockman, Delegate from the Colorado Chapter of the Student A.M.A., and commended him for his fine report to the Board of Trustees.

There was no unfinished business to discuss and at this point in the proceedings the House met in brief Executive Session.

New business

Dr. Leo J. Nolan of Lakewood offered the following resolution to the House from the Clear Creek County Medical Society:

RESOLUTION

WHEREAS, There is no official recognition of general practice sections in accredited hospitals; and

WHEREAS, It has been recommended by a surveyor of the Joint Commission for Hospital Accreditation that action

be taken at the county and state level to obtain official recognition for a general practice section; therefore, be it

RESOLVED, That the Colorado State Medical Society go on record as recommending that a member of the American Academy of General Practice be included on the Joint Commission of Hospital Accreditation.

There was no discussion and Speaker Bolton referred the resolution to the Reference Committee on Scientific Work. There was no further new business.

After a brief announcement of committee reports to be heard at the final meeting of the House, Speaker Bolton entertained a motion to cancel the optional meeting scheduled Thursday, September 10. The motion was seconded and carried without dissent. Speaker Bolton declared the Second Meeting of the House adjourned and asked the Delegates to reconvene at 8:00 o'clock a.m., Friday, September 11, 1959, in the Ballroom of the Brown Palace West Hotel for the third and final meeting of the 89th Annual Session.

THIRD MEETING

Friday, September 11, 1959

Speaker Vernon L. Bolton, M.D., Colorado Springs, called the House to order at 8:00 o'clock a.m. There was no further credentials report. Roll call disclosed a quorum was present. The list of those in attendance at this meeting was by motion of the House, without dissent, revised as follows:

El Paso County Medical Society—Alternates James H. Donald and Hubert H. Rodman were seated to replace absent Delegates James V. Carris and Matthew A. Hetrick. Denver County Society—Alternate F. A. Garcia to replace absent Delegate Dale M. Atkins.

The House voted to dispense with the reading of the condensed minutes of the Second Meeting.

Election of officers

Executive Secretary Sethman reread the report of the Nominating Committee as it was submitted to the Second Meeting of the House on September 9th.

No supplements or amendments thereto had been subsequently presented by the committee.

Speaker Bolton proceeded to conduct the elections. With respect to each office concerned in the report of the Nominating Committee, the Speaker inquired if there were further nominations from the floor of the House, allowed a reasonable time for any Delegate to make such a nomination, and none were made. In each instance the Chair, hearing no further nominations for any of the offices, declared the nomination closed and entertained a motion to elect the candidate. There were no dissenting votes, and the Chair in each instance officially declared the man elected.

The following proceedings were recorded, among others, during the election of officers:

Speaker Bolton: I hereby declare Dr. Cyrus

W. Anderson elected President-Elect. (Applause.) The Chair will appoint Dr. James M. Perkins and Dr. Leo W. Bortree to escort Dr. Anderson to the platform.

President-Elect Anderson: Friends, and I am sure you are all my friends, I consider this a great honor and a great responsibility. I realize that. I am very proud to think that you had that much confidence in me that you have elevated me to this office at a time when there are a great many problems. I hope that I will be worthy of your choice and I do thank you very much.

At the conclusion of the election of officers further revisions in the list of those present at this meeting of the House were as follows:

On motion by Credentials Committee Chairman Curfman, Alternate George Maresh of Denver replaced Delegate Sam W. Downing. Donald Schiff, Alternate from Arapahoe County, replaced Delegate James Kennedy.

Vice Speaker Covode called for additional reports from any board, officer or committee.

Supplemental Report of Reference Commitee on Constitution, By-Laws and Credentials

The following report submitted by Chairman George Curfman was heard and, without discussion, adopted without dissent.

Your reference committee has reviewed the report of the Ad Hoc Committee on By-Law Revisions as published on pages 53, 54 and 55 of the Handbook, and the supplement to the report of the Ad Hoc Committee on By-Law Revisions as published on pages 55 through 62 of the Handbook. The committee recommends that they be submitted to the Board of Trustees for further study. It is further recommended that the Board of Trustees refer this matter to the House of Delegates at the Interim Session in 1960 for information only and for action at the House of Delegates meeting at the Annual Session in 1960. Your committee believes that this sweeping revision of our governmental structure is not well enough understood by the House of Delegates for action at this time. The revision would be of primary advantage to the executive functioning of the Society, particularly in the way of streamlining such functions. There is question as to whether such changes would actually correct existing deficiencies in our mode of operation, and the Board of Trustees should be given the opportunity to evaluate such proposed changes.

GEORGE CURFMAN, M.D., Chairman
WINTHROP B. CROUCH, M.D.
JOHN A. DAVIS, M.D.
H. HARPER KERR, M.D.

Second Report of the Reference Committee on Scientific Work

In the absence of Chairman James M. Kennedy, Dr. William A. H. Rettberg presented the following report, which was adopted without dissent:

Action of the reference committee on resolution introduced by the Clear Creek Valley Medical Society relating to the Joint Commission on Accreditation of Hospitals.

After consultation with officials of the American Academy of General Practice, we find that the contents of this resolution have already been discussed with the Joint Commission for Hospital Accreditation, and that this action is not feasible at this time. Your reference committee therefore does not recommend approval of this resolution.

JAMES M. KENNEDY, M.D., Chairman
WILLIAM A. H. RETTBERG, M.D.
EDWARD C. BUDD, M.D.

Speaker Bolton: "Before we go any further on this next order of business, we need to come back just a moment:

"In Dr. Curfman's preliminary report, before,

there was one paragraph that constituted a change in our By-Laws, by deleting paragraph b, section 3, chapter I, page 10, Articles of Incorporation, Constitution and By-Laws, and substituting therefor the following:

b. Active Members Junior—Active members shall be accorded this classification for a total period of three years of active medical practice, whether continuous or interrupted by military service or additional formal training—specifically full-time A.M.A. approved internship, residency, fellowship, or preceptorship. Any period of active medical practice in any locality will be included as a part of the three-year period of eligibility for Active Junior Membership. Active Members Junior may not be required to pay annual dues or assessments in an amount to exceed one-half the dues or assessments against Active Members Senior.

"I think this should now be voted upon, since it has been before the House the proper length of time, and which does require a two-thirds majority vote of all the Delegates.

"Since this was already previously moved and seconded we now call for your vote for ratification of this change. I think we will ask you to stand so we may determine if we have to have an actual count.

"All those in favor of that change in the By-Laws please stand.

(Mr. Sethman made the count and reported to Speaker Bolton.)

Well over. Carried. Thank you.

Report of the Reference Committee on Insurance and Prepayment Plans

The report delivered by Chairman V. V. Anderson, amended and corrected with reference to Sections 6 and 7, and brief discussion pertaining thereto, was adopted section by section and as a whole as follows:

(1) Your reference committee recognizes the vital importance and hair-trigger characteristic of the subject matter presented to it for review. Consequently, this committee has carefully read all of the content given to us, both the Handbook and the material presented to this House of Delegates which was not in the Handbook.

The greater part of two and one-half days has been spent in sifting this material and information, and during this time our meetings have been open to all concerned.

We have been fortunate in obtaining the cooperation of all of the members asked to give us information, and all sides of the question have been well heard.

In order to get an intelligent idea of the problems, and also to get some hints toward a possible solution, members of the Colorado Society of Internal Medicine, several in number, and among them Dr. Rettberg, Dr. Mahony, Dr. Nims, and Dr. Curfman—these men being familiar with the problem from the point of view of the Colorado Society of Internal Medicine—were asked to testify. Members of the Blue Shield Fee Schedule Advisory Committee of Blue Shield itself and of its subcommittee, were heard.

President John Zarit, an officer of Blue Shield, and long familiar with its operation, appeared several times on request. Dr. Fred Good, President of the Board of Blue Shield, gave straightforward answers, and furnished valuable information. Mr. Vance was also present by request, and his answer to questions clarified otherwise vague points.

Your reference committee wishes to congratulate and commend the calm and courteous manner in which all participants, without exception, conducted themselves throughout these discussions.

As a result of these discussions, your committee unanimously recognizes and admits that the internists are not now equitably compensated for their services as compared with other specialty groups, especially as compared with compensation for surgical procedures. The reference committee also recognizes that this has been the case since the inception of the Blue Shield plan, due principally to the fact that the Blue Shield plan was initially conceived as a surgical coverage, and to the fact that it has never, perhaps erroneously, been expanded to cover adequately non-surgical medical services. It is also increasingly obvious that the public wants a much wider and more comprehensive coverage.

These remarks are submitted to this House as an explanatory introduction. Using the foregoing remarks as an explanatory introduction, the following recommendations, remarks, and suggestions represent, to the best of their ability, the considered and unanimous opinion of the members of this reference committee.

(2) Your reference committee recommends approval of that portion of the report of the Board of Trustees entitled "Old Age Medical Care Plan" as it appears on page 14 of the Handbook. In addition, your reference committee recommends the adoption of the resolution regarding the Colorado Old Age Pension Plan as adopted at the regular meeting of the Morgan County Medical Society and as presented to this annual meeting of this House of Delegates by Dr. R. B. Richards, with the exception that the portion of the resolution beginning in the fifth line, and reading "and that before final acceptance of the Plan they contact all component societies to obtain their advice and recommendations" be deleted, with the further recommendation that this resolution be adopted for the information and guidance of those concerned with this problem for whatever help they may derive therefrom.

Your reference committee deletes the above-quoted line because such a directive involves a considerable expense to the Society, and would be of questionable value at best, since the time consumed in contacting all of the component societies, with their different dates of future meetings, would cause the opinions of many component societies to reach the central office after the renegotiation contracts have been made. It is also the opinion of this reference committee that each component medical society is adequately represented by Delegates in this House, or should be, and consequently the wishes of the component society will be reflected in the action of its Delegate.

(3) Your reference committee acknowledges receipt of a letter from the Denver County Medical Society, signed by Dr. Marshall Nims. This letter has not been read to this House of Delegates. It has been carefully read by this committee, and embodies essentially the same ideas and criticisms as the resolution of the Morgan County Medical Society in the opinion of this committee. Dr. Nims has stated before

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this committee that he concurs as to the sameness of content of this letter.

Your reference committee recommends that this letter be referred to the Board of Trustees for appropriate action.

Your reference committee believes that the negotiations of future contracts with the Old Age Pension Plan is in competent hands, and also that the present representatives of OAP with which we have to deal—that is, Dr. Paul Hartendorp and Mr. Guy Justis—have been cooperative, and that within the limits outlined by law they are as fair as possible. It is the opinion of your reference committee that renegotiations should be carried out to the best general interests of all concerned, but that we should keep in mind that in this instance we are dealing with the Constitution of the State of Colorado and with the state's laws, and that sweeping changes advanced by us may not be possible, and could result in more harm than good to us, especially at this time.

(4) Your reference committee recommends approval of that portion of the Board of Trustees report entitled "Medicare," as it appears on page 15 of the Handbook.

(5) Your reference committee recommends approval of the report of the Subcommittee on Prepayment Services as it appears on pages 35 and 36 of the Handbook, with the correction of the typographical error by the insertion of the word "not" in the second paragraph on page 36, the fourth line, so that the fourth line reads "whenever a medical problem could not be settled directly." In addition, your committee recommends approval of the supplementary report of this subcommittee, as read by Dr. George Buck before this House, and entitled "Supplemental Report, Subcommittee on Prepayment Services."

Your reference committee is of the opinion that the nature of the work of this subcommittee is of great potential value to this Society in that it establishes contact with insurance companies, providing a means of communication and mutual cooperation, which may well result in time-saving simplification of completing insurance forms, ways of adjudication of difficulties, and in many ways furthering mutual understanding. Your reference committee commends the beginning of progress made by this committee and urges that it continue its work.

(6) Your reference committee recommends approval of the report of the Blue Shield Fee Schedule Advisory Committee as it appears on page 62 of the Handbook, and as presented to each member of the House of Delegates on September 8, 1959.

Your reference committee was furnished with three copies of the fee schedule which detailed the fees and benefits of all four plans. Time did not permit us to examine each line of this schedule, but a general scanning indicates that the new fee schedules are approximately 75 per cent and 125 per cent of the old "preferred plan."

It is obvious that a tremendous amount of time, thought, and energy has been contributed by the members of this committee, and other members of this Medical Society, toward creating this new plan and schedule. The result is a significant advance in coverage and benefit to more people, and a much more realistic remuneration to the medical profession. After a study of the submitted report, and questioning of those concerned with the administrative, actuarial, and selling divisions necessary to its implementation, your reference committee is convinced that the new plan is actuarily sound, that it is a long step forward, and that the production of such a plan involves a staggering amount of work and worry. The members of this Blue Shield Committee are, without question, completely sincere and have done their utmost to bring into being a workable, fair, plan. They admit that it is imperfect, and your reference committee realizes that such a plan probably never can be perfect.

Your reference committee highly commends the members of the Blue Shield Fee Schedule Advisory Committee. We deeply appreciate their help, and the members of the Colorado State Medical Society owe them a vote of thanks, and should be proud that our Society has such members.

Dr. Robert Bosworth: "At the first session of the House of Delegates I referred to what I considered the serious problem of service benefit income level which is the basis of our present Blue Shield Plan, a rather creeping, malignant problem, when the future years of deliberations and changes

of plans, new plans, etc., are considered, particularly in regard to the effort of the Blue Shield to be the bulwark against socialized medicine and particularly in regard to the Blue Shield's prestige among the patients in order to promote better plans every year.

"I want to point out that in my opinion that affects every doctor in the state, not just specialists. There has been a lot of discussion during this session about excessive differences, etc., but this, to my opinion, does not affect specialists only by any means, it affects every doctor in the state. This is more than self-restriction. This regulating fees of 90 per cent of the patients who buy the plan is restricting at an income level with a limit of $9,000 now, and soon, perhaps, $12,000 to $15,000, is indirect fixing of fees and is a foot in the door of fixing the fees by any party.

"By the time the children of many of us may want to enter the profession there will be no leeway for professional judgment and professional integrity regarding fees as related to Blue Shield insurance and other insurance agents, and government may well follow suit, because we apparenfly approve of direct or indirect fixing of fees.

"Again I say I think this applies to every doctor and I think this applies to the years ahead and not just to this session of deliberation regarding any new Blue Shield plan."

There was no further discussion. A voice vote followed and section 6 was adopted.

(7) Your reference committee does not recommend approval of the resolution of the Colorado Society of Internal Medicine as read before this House of Delegates on September 8, 1959, because it is our opinion that the plan proposed therein has not had sufficient study for the House of Delegates to take action thereon.

A letter from the Colorado Springs Society of Internal Medicine was reviewed. This letter was also read before the House of Delegates.

Your reference committee recognizes that the services of the internists are not adequately covered by existing Blue Shield plans, and we are in sympathy with their problem. Innumerable witnesses have been heard, and testimony further convinces your reference committee that the Colorado State Medical Society, through its various channels, should take more definite cognizance of these inadequacies, as well as those existing elsewhere. Your reference committee urges that the Colorado Society of Internal Medicine, through its established channels, pursue its goal in persistent manner. Your reference committee, by virtue of the evidence given us during the hearings of the past two days, believes: First, that all parties concerned are sincere. Second, that there have been errors of commission and omission on both sides, to further complicate the solution. And third, that a new avenue of approach to this problem is in order.

Your reference committee has been assured by the President of Blue Shield that he will, when requested, appoint his own committee to meet with one provided by the Colorado Society of Internal Medicine. Your reference committee urgently suggests that the Colorado Society of Internal Medicine make in writing a statement of their problems, together with possible proposed solutions, and present these directly to the President of the Blue Shield Plan.

To further clarify this procedure, your reference committee recommends that this House of Delegates direct the President of Blue Shield to meet with a committee from the Colorado Society of Internists when he is contacted by them.

At this point in the proceedings a discussion was had to clarify a point concerning the letter from the Colorado Springs Society of Internal Medicine. Then Dr. W. A. H. Rettberg, of Denver, made the following remarks:

Dr. Rettberg: "The Colorado Society of Internal Medicine wants to thank this committee and the members of the House for the very fair treatment we have received here. I would only like to call your attention to the fact that we are approving Standard Plan A and Preferred Plan A without the participation of the Colorado Society of Internal Medicine.

"I do not want the House to think that we are going on record now as going along with these new plans when we have already been instructed by the report of Dr. Anderson that we should seek out further negotiation with the President and Trustees of Blue Shield. I think that is very obvious. We have all voted here without a dissenting vote to implement the plan of the Advisory Committee to Blue Shield. But if you have listened to this report you understand that we are still in the process of negotiation, and I want this for the record."

After further discussion of the letter from the Colorado Springs Society of Internal Medicine, this section of the report was adopted.

(8) Your reference committee has carefully reviewed the minority report of the Blue Shield Fee Schedule Advisory Committee, as read by Dr. Mahony before this House of Delegates on September 8, 1959.

The minority report reflects the difficulties encountered by the Colorado Society of Internists in their attempts to resolve their fee schedule dilemma. Your reference committee has outlined a procedure which the internists may follow in the future to insure their getting a hearing and at the same time the assistance and advice that will lead to an ultimate satisfactory solution.

Your reference committee feels that no problems, however large or small, should be permitted to die in a committee without jurisdiction. It should be incumbent on all officers

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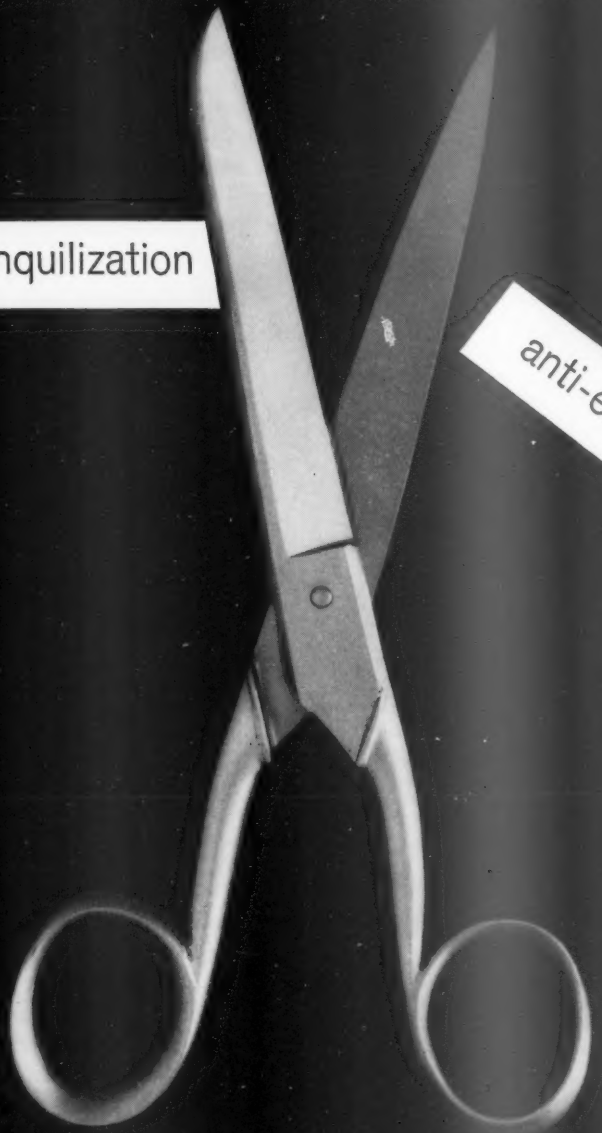

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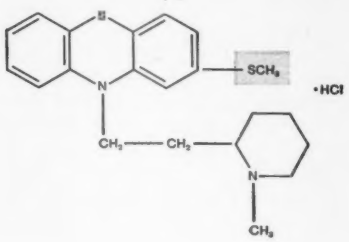
THIORIDAZINE HCl

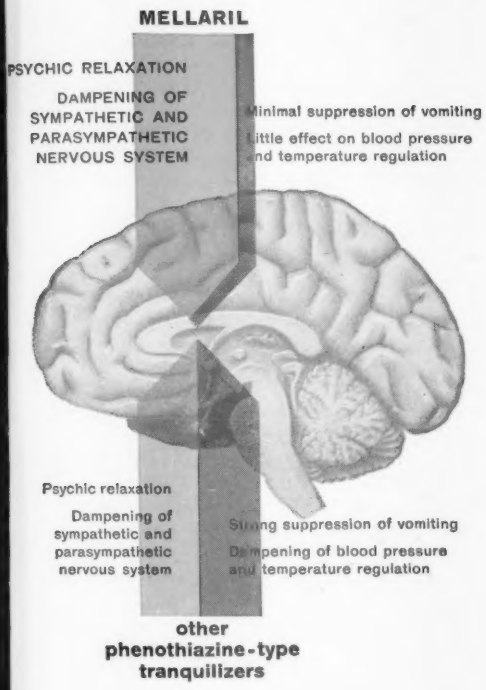
is virtually free of such toxic effects as · jaundice · Parkinsonism · blood dyscrasia

"Thioridazine [MELLARIL] is as effective as the best available phenothiazine, but with appreciably less toxic effects than those demonstrated with other phenothiazines. ... This drug appears to represent a major addition to the safe and effective treatment of a wide range of psychological disturbances seen daily in the clinics or by the general practitioner."*

a new advance in tranquilization:
greater specificity of tranquilizing action results in fewer side effects



The presence of a thiomethyl radical ($S\text{-}CH_3$) is unique in Mellaril and could be responsible for the relative absence of side effects and greater specificity of psychotherapeutic action. This is shown clinically by:



1 **A specificity of action on certain brain sites in contrast to the more generalized or "diffuse" action of other phenothiazines. This is evidenced by a lack of appreciable anti-emetic effect.**

2 **Less "spill-over" action to other brain areas — hence, absence of undue sedation, drowsiness or autonomic nervous system disturbances.**

3 **A notable absence of extrapyramidal stimulation.**

4 **Lack of impairment of patient's normal drive and energy.**

5 **Virtual freedom from such toxic effects as jaundice, photosensitivity, skin eruptions, blood forming disorders.**

INDICATION	USUAL STARTING DOSE	TOTAL DAILY DOSAGE RANGE
ADULTS: Mental and Emotional Disturbances:		
MILD—where anxiety, apprehension and tension are present	10 mg. t.i.d.	20-60 mg.
MODERATE—where agitation exists in psychoneuroses, alcoholism, intractable pain, senility, etc.	25 mg. t.i.d.	50-200 mg.
SEVERE—in agitated psychotic states as schizophrenia, manic depressive, toxic psychoses, etc.:		
Ambulatory	100 mg. t.i.d.	200-400 mg.
Hospitalized	100 mg. t.i.d.	200-800 mg.
CHILDREN: BEHAVIOR PROBLEMS IN CHILDREN	10 mg. t.i.d.	20-40 mg.

MELLARIL Tablets, 10 mg., 25 mg., 100 mg.

*Ostfeld, A. M.: Scientific Exhibit, American Academy of General Practice, San Francisco, April 6-9, 1959

SANDOZ

Organization cont. from page 147

and committee chairmen of the Colorado State Medical Society to expedite the Society's business by channeling it to appropriate committees or boards that do have jurisdiction.

Your reference committee hopes that the Colorado Society of Internal Medicine will reconsider proposals set forth by its Executive Committee and reconsider its suggestion that members withdraw from participation in Blue Shield on an individual basis. Since Blue Shield was originally conceived to cover surgical procedures, it has naturally been difficult to expand into nonsurgical fields, and progress is very slow. However, rapidly changing times make it almost inevitable that a more comprehensive and equitable medical plan of coverage will eventually be introduced.

(9) Your reference committee received and reviewed that portion of President John Zarit's address before the House of Delegates which related to subject matter concerning this reference committee.

Your reference committee commends the content of that address as delivered to us. We recognize in Dr. Zarit a man of the very highest ideals, of honesty, of devotion to his profession, and a man who has contributed a considerable amount of philosophy and understanding to the Colorado State Medical Society.

V. V. ANDERSON, M.D., Chairman
SAMUEL B. CHILDS, M.D.
WILLIAM CONDON, M.D.
WILLIAM CURTIS, M.D.
E. B. LIDDLE, M.D.
WILLIAM A. LIGGETT, M.D.
WILLIAM H. RYDER, M.D.

There was no further discussion and this report was approved as a whole without dissent.

There was no further business, and upon inquiry by the Chair, the Secretary reported that all reference committees had completed their business and the official desk was clear. After the House heard announcements, Speaker Bolton declared the House adjourned, without day, at 9:15 a.m., September 11, 1959.

Colorado Radiological Society Officers for 1960

Officers for the Colorado Radiological Society for the year 1959-1960 are Vernon L. Bolton, M.D., President; Paul E. RePass, M.D., Vice President; Charles F. Gaylord, Treasurer, and Bertram L. Pear, M.D., Secretary. The society meets at the Denver Athletic Club on the third Friday of each month. A film reading session, scientific program, and business meeting are held at that time.

Tagno, Tuberculosis Association of Greater New Orleans

Mycobacterial and mycotic diseases with special reference to childhood will be discussed by a number of medical authorities at a one-and-a-half day conference in New Orleans, Louisiana, on December 10-11, 1959.

The event is to be sponsored by TAGNO, the Tuberculosis Association of Greater New Orleans, and cosponsored by the Louisiana State Medical School, the Tulane University School of Medicine, and the Orleans Parish Medical Society.

The conference will be underwritten by TAGNO and there is no registration charge. Specialists, general practitioners, pediatricians, and graduate nurses are being invited to attend the sessions.

The entire conference will take place in the comfortable new auditorium of the L.S.U. Medical School, located in the heart of downtown New Orleans.

Doctors hold school for careless drivers

If careless drivers could see the kinds of injuries they could cause themselves and others, they might think twice before disobeying the law. At least that's the thinking behind Summit County Medical Society's participation in a school for traffic violators in Akron, Ohio.

The safety school was started by the local Junior Chamber of Commerce and consists of a four-week course attended each Monday night by reckless drivers. "Students" are assigned to the school by the municipal traffic court and "teachers" are representatives of an independent insurance group, the state highway patrol, and local courts and the traffic safety committee of the county medical society.

Four orthopedic surgeons from the society illustrate their 45-minute lecture with x-rays and color slides showing just how serious automobile injuries can be. Statistics on the number of injuries resulting from local accidents are emphasized and the meeting ends with a showing of the movie "On Impact" by the Ford Motor Company. (This movie can be ordered from A.M.A.'s Film Library.)

Other sessions include a discussion of driver responsibility under the Ohio financial responsi-

bility law by the insurance group, a lecture on the relation of accidents to law violation by the state patrol, and a review of traffic laws by representatives of the courts.

It's difficult to measure the results of the program but the doctors have noticed that very few violators have had to take the course for a second time.

Bowen's disease and its relationship to systemic cancer

The characteristic finding in the disease described by Bowen is a chronic solitary lesion composed of lenticular papules. The histologic picture of atypical epithelial proliferation also occurs in multiple, nonelevated, scaly or crusted plaques. Specimens for study were obtained from 35 patients after death and were compared with similar materials from 35 patients with senile keratosis, 35 with squamous-cell carcinoma of the skin, 139 with exfoliative dermatitis, and many other patients with other cutaneous diseases. The average age of onset for the 35 patients with Bowen's disease was 54 years; the duration of the lesion from onset to surgery ranged from five months to 30 years. The lesions ranged in diameter from 0.7 to 13 cm with a median of 1.9 cm. They usually appeared as erythematous, pigmented, crusty, scaly fissured, keratotic plaques. Their configuration varied from round plaques, sharply demarcated from the surrounding tissue, to an irregular, polycyclic, lenticular pattern. They were firm, indurated, rough, and granular to palpation. The first lesion surgically removed was most frequently diagnosed as squamous-cell or basal-cell carcinoma, and only once was the diagnosis of Bowen's disease made at the first examination of a specimen. Surgical excision of the lesion is the recommended treatment; the need for sufficiently wide excision was indicated by the fact that in four patients the lesions were clearly invasive and in two others widespread metastases appeared. The evidence of an association of Bowen's disease with internal and cutaneous cancer was convincing, and it is suggested that the lesions are cutaneous manifestations of a systemic carcinogenic disease process.

—James H. Graham and Elson B. Helwig: A.M.A. Arch. Dermat. 80:133-159 (Aug.) 1959.

Want to give a paper?

The Scientific Program Committee of the Colorado State Medical Society will receive applications for places on the Society's Midwinter Clinical Session program until Dec. 1, 1959. The session will be held in Denver Feb. 16-19, 1960. If you have a paper you would like to present, write today to the Committee, 835 Republic Building, Denver 2.

CITRA

BOYLE & Company Pharmaceuticals, Bell Gardens, California

NEW CITRA FORTE CAPSULES...When a Narcotic is Indicated for Colds ■ 5.0 mg. Dihydrocodeinone ■ 3 Antihistamines ■ Decongestant ■ APC ■ Ascorbic Acid ■ Prompt patient relief. New CITRA FORTÉ CAPSULES contain the highest potency cough suppressant available...Dihydrocodeinone (5.0 mg.). Fast, effective relief from nasal congestion, muscular aches and other common cold symptoms is rendered with multiple antihistamines and decongestant. And for patients who have difficulty with syrups, CITRA FORTÉ CAPSULES provide the easy-to-swallow economical answer. Not promoted to the laity. Dosage: 2 capsules immediately—followed by 1 capsule every 3-4 hours.

THE CITRA SELECTOR CHART... "Professionally Promoted Medications For the Cough and Cold Season"

products	indications	ingredients	dosage
CITRA FORTE CAPSULES (New)	When a narcotic is indicated for colds	Cough Suppressant / Antihistamines / Decongestant / APC / Ascorbic Acid	2 capsules immediately, then 1 capsule every 3-4 hours
CITRA DEL CAPSULES (New)	Prolonged action cold treatment	Decongestant / Analgesic / Antipyretic / Antihistamines / Ascorbic Acid	2 capsules immediately, then 1 capsule every 8 hours
CITRA NASAL SPRAY (New)	Relief of congestion in colds rhinitis, and sinusitis	Antihistamines / Antibiotic / Decongestant	Spray one time into each nostril and repeat after few minutes.

wider latitude in adjusting dosage

ARISTOGESIC is particularly effective for relief of chronic — but less severe — pain of rheumatic origin. ARISTOGESIC combines the anti-inflammatory effects of ARISTOCORT® Triamcinolone with the analgesic action of salicylamide, a highly potent salicylate. Dosage requirements for ARISTOGESIC are substantially lower than generally required for each agent alone. The exceptionally wide latitude of dosage adjustment with ARISTOGESIC permits well-tolerated therapy for long periods of time with fewer side effects.

Indications: Mild cases of rheumatoid arthritis, tenosynovitis, synovitis, bursitis, mild spondylitis, myositis, fibrositis, neuritis, and certain muscular strains.

Dosage: Average initial dosage: 2 capsules 3 or 4 times daily. Maintenance dosage to be adjusted according to response.

Precautions: All precautions and contraindications traditional to corticosteroid therapy should be observed. The amount of drug used should be carefully adjusted to the lowest dosage which will suppress symptoms. Discontinuance of therapy must be carried out gradually after patients have been on steroids for prolonged periods.

Each ARISTOGESIC Capsule contains:

ARISTOCORT® Triamcinolone	0.5 mg.
Salicylamide	325 mg.
Dried Aluminum Hydroxide Gel	75 mg.
Ascorbic Acid	20 mg.

Supply: Bottles of 100 and 1,000.

gesic® Capsules

Steroid-Analgesic Compound LEDERLE

Lederle

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

The Colorado State Medical Society

Midwinter Clinical Session, February 16-19, 1960
Denver

President: John L. McDonald (Chairman of the Board), Colorado Springs.
President-elect: Cyrus W. Anderson, Denver.
Vice President: J. Alan Shand (Vice Chairman of the Board), La Junta.
Treasurer: William C. Service, Colorado Springs, 1962.
Additional Trustees: Carl W. Swartz, Pueblo, 1960; Fred R. Harper, Denver, 1961; Walter M. Boyd, Greeley, 1961; Carl H. McLauthlin, Denver, 1962.
Delegates to A.M.A.: Kenneth C. Sawyer, Denver, 1960; (Alternate, Gatewood C. Milligan, 1960); E. H. Munro, Grand Junction, 1961; (Alternate, Harlan E. McClure, 1961); I. E. Hendryson, Denver, 1961; (Alternate, C. C. Wiley, Longmont, 1961).
Executive Secretary: Mr. Harvey T. Sethman, 835 Republic Building, Denver 2, Colorado; telephone AComa 2-0547.

Montana Medical Association

Interim Session, February 26-27, 1960
Helena

President: Leonard W. Brewer, Missoula.
President-elect: Raymond F. Peterson, Butte.
Vice President: Everett H. Lindstrom, Helena.
Secretary-Treasurer: W. E. Harris, Livingston.
Assistant Secretary-Treasurer: Jess T. Schwidde, Billings.
Executive Committee: Leonard W. Brewer, Missoula; Raymond F. Peterson, Butte; Everett H. Lindstrom, Helena; W. E. Harris, Livington; Jess T. Schwidde, Billings; John A. Layne, Great Falls; Herbert T. Caraway, Billings.
Delegate to American Medical Association: Paul J. Gans, Lewiston; alternate, S. C. Pratt, Miles City.
Executive Secretary: Mr. L. R. Hegland, P.O. Box 1692, Billings; telephone 9-2585.

Nevada State Medical Association

Annual Meeting, 1960, Las Vegas
(Dates to be announced)

President: Ernest W. Mack, Reno.
President-elect: Wesley W. Hall, Reno.
Secretary-Treasurer: William A. O'Brien, III, Reno.
Delegate to American Medical Association: Wesley W. Hall, Reno; alternate: Earl N. Hillstrom, Reno.
Executive Committee: Roland Stahr, Reno; Ernest W. Mack, Reno; William A. O'Brien, III, Reno; Wesley W. Hall, Reno; Earl N. Hillstrom, Reno; Stanley L. Hardy, Las Vegas; Thomas S. White, Boulder City; John M. Read, Elko; John M. Moore, East Ely; William M. Tappan, Reno.
Executive Secretary: Mr. Nelson B. Neff, P. O. Box 188, Reno; telephone FA. 3-6788.

New Mexico Medical Society

Annual Meeting, May 10-13, 1960
Albuquerque

President: Lewis M. Overton, Albuquerque.
President-elect: Allan L. Haynes, Clovis.
Vice President: William E. Badger, Hobbs.
Secretary-Treasurer: Thomas L. Carr, Albuquerque.
Councilors: Wendell H. Peacock, Farmington, 1960; Georgè W. Prothro, Clovis, 1960; Gerald A. Slusser, Artesia, 1960; W. J. Hossley, Deming, 1961; Guy E. Rader, Albuquerque, 1961; Robert P. Beaudette, Raton, 1962; William R. Oakes, Los Alamos, 1962.
Delegate to American Medical Association: Earl L. Malone, Roswell, 1960; Alternate: Samuel R. Ziegler, Espanola, 1960.
Executive Secretary: Mr. Ralph R. Marshall. 220 First National Bank Building, Albuquerque; telephone CH. 2-2102.

The Utah State Medical Association

Annual Session, September 14-16, 1960
Salt Lake City

President: I. Bruce McQuarrie, Ogden.
President-elect: Wallace S. Brooke, Salt Lake City.
Secretary: J. Poulson Hunter, Salt Lake City.
Treasurer: Robert M. Dalrymple, Salt Lake City.
Councilors: Box Elder, 1960, D. L. Bunderson, Brigham City; Cache Valley, 1960, C. J. Daines, Logan; Carbon County, 1960, A. R. Demman, Helper; Central Utah, 1959, Stanford Rees, Gunnison; Salt Lake, 1960, Richard W. Sonntag, Salt Lake City; Southern Utah, 1960, James S. Prestwich, Cedar City; Uintah Basin, 1960, R. Bruce Christian, Vernal; Weber County, 1961, Wendell J. Thompson, Ogden; Utah, 1959, R. E. Jorgenson, Provo.
Executive Committee: I. Bruce McQuarrie, Ogden; U. R. Bryner, Salt Lake City; Wallace S. Brooke, Salt Lake City; J. Poulson Hunter, Salt Lake City; Robert M. Dalrymple, Salt Lake City.
Delegate to American Medical Association: Kenneth B. Castleton, Salt Lake City; Alternate, Drew Petersen, Ogden.
Executive Secretary: Mr. Harold Bowman, 42 South Fifth East Street, Salt Lake City 2; telephone EL. 5-7477.

The Wyoming State Medical Society

Annual Session, September 7-10, 1960
Jackson Lake Lodge

President: Benjamin Gitlitz, Thermopolis.
President-elect: Francis A. Barrett, Cheyenne.
Vice President: S. J. Giovale, Cheyenne.
Secretary: Frederick H. Haigler, Casper.
Treasurer: C. D. Anton, Cheyenne.
Councilors: Albany County, B. J. Sullivan, Laramie; Carbon County, Guy M. Halsey, Rawlins; Converse County, Roman J. Zwalsh, Glenrock; Fremont County, Bernard D. Stack, Riverton; Goshen County, O. C. Reed, Torrington; Laramie County, S. J. Giovale, Cheyenne; Natrona County, Frederick H. Haigler, Casper; Sheridan County, Ralph Arnold, Sheridan; Sweetwater County, R. C. Stratton, Green River; Teton County, Vacancy; Uinta County, J. S. Hellewell, Evanston; Northeastern Wyoming, Virgil Thorpe, Newcastle; Northwest Wyoming, John H. Froyd, Worland.
Delegate to A.M.A.: A. T. Sudman, Green River, 1960; Alternate, B. J. Sullivan, Laramie, 1960.
Executive Secretary: Mr. Arthur R. Abbey, Box 2036, Cheyenne; telephone 2-5525.